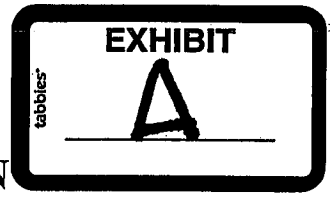
REPORT OF THE



FULL SCOPE MARKET CONDUCT EXAMINATION

FOR THE

TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE

OF

BLUECROSS BLUESHIELD OF TENNESSEE, INC.
(NAIC #54518)

CHATTANOOGA, TENNESSEE

As of September 30, 2004

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June 13, 2005

Honorable Paula A. Flowers
Commissioner
Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
5th Floor
Nashville, Tennessee 37243

Dear Commissioner Flowers:

Under authority delegated by you, pursuant to Tennessee statutes, rules and regulations, a full scope market conduct examination has been conducted on the business affairs of:

BlueCross BlueShield of Tennessee, Inc.
Statutory Home Office:
801 Pine Street
Chattanooga, Tennessee 37402

(hereafter referred to as the "Company.") The report of examination is herewith respectfully submitted.

FORWARD

This examination report as of September 30, 2004, shows the Tennessee insurance activities of the Company. The report of market conduct examination is by test and all tests applied during the examination with noted errors are reported.

SCOPE OF EXAMINATION

This Full Scope Market Conduct Examination of the Company was conducted pursuant to the authority of the Commissioner of the Tennessee Department of Commerce and Insurance ("TDCI"). The Commissioner of TDCI appointed Huff, Thomas & Company to perform a market conduct examination of the Company. This examination commenced on December 1, 2004 and was concluded on August 28, 2006. The examination is as of September 30, 2004.

The examination was limited to the Comprehensive (hospital and medical) and Medicare Supplement lines of business. The examination did not include the dental and Federal Employee Health Benefit Plan lines of business. The Federal Employee Health Benefit Plan represented thirteen percent (13%) of total premium revenue for the examination period.

The examination was performed to determine compliance with applicable Tennessee statutes, rules and regulations. The examination was performed in accordance with the procedures developed by the National Association of Insurance Commissioners ("NAIC") and the TDCI. The following phases were included in the examination:

Company Operations Management
Complaint Handling
Grievance Procedures
Marketing and Sales
Network Adequacy
Producer Licensing
Provider Credentialing
Policyholder Services
Quality Assessment and Improvement
Underwriting and Rating
Utilization Review
Claims Practices

The examination focused on the methods used by the Company to manage its operations for each of the business areas subject to this examination. The examination includes an analysis of how the Company communicates its instructions and intentions to its staff, how it measures and monitors the results of those communications, and how it reacts to and modifies its communications based on the resulting findings of the measurement and monitoring activities. The examiners also determined whether this process is dynamic

and results in enhanced compliance activities. Because of the predictive value of this form of analysis, focus is then made on those areas in which the process used by management does not appear to be achieving appropriate levels of statutory and regulatory compliance. Most areas are nevertheless tested to see that the Company complies with Tennessee statutes and rules.

METHODOLOGY

This examination is based on the standards and tests for a market conduct examination of a health insurer found in Chapter XVII of the NAIC Market Conduct Examiners Handbook and in accordance with Tennessee statutes and rules and regulations.

Some of the standards were measured using a single type of review, while others used a combination or all types of review. The types of review used in this examination fall into three (3) general categories: Generic, Sample, and Electronic.

A "Generic" review indicates that a standard was tested through an analysis of general data gathered by the examiner, or provided by the examinee in response to queries by the examiner.

A "Sample" review indicates that a standard was tested through direct review of a random sample of files using automated sampling software. For statistical purposes, an error tolerance level of seven percent (7%) was used for claims and a ten percent (10%) tolerance was used for all other types of review. Pass is a resulting error rate lower than these percentages. Fail is a resulting error rate equal to or greater than these percentages. The sampling techniques used are based on a ninety-five percent (95%) confidence level.

An "Electronic" review indicates that a standard was tested through use of a computer program or routine applied to a download of computer records provided by the examinee. This type of review typically reviews one hundred percent (100%) of the records of a particular type.

Standards were measured using tests designed to adequately measure how the Company met certain benchmarks. Each standard applied is described and the result of testing is provided under the appropriate standard. The standard, its statutory authority under Tennessee statutes, and its source in the NAIC Market Conduct Examiners Handbook are stated and contained within a bold border.

Each standard is accompanied by a "Comment" describing the purpose or reason for the standard. "Results" are indicated, examiner's "Observations" are noted, and in some cases, a "Recommendation" is made. Comments, Results, Observations and Recommendations are kept with the appropriate standard.

EXECUTIVE SUMMARY

This full scope market conduct examination focused on compliance with specific sections of statutes, rules and regulations that were applicable.

Of the one hundred four (104) standards tested, the Company passed one hundred one (101) and failed three (3). Six (6) additional areas warranted a recommendation.

PREVIOUS EXAMINATION FINDINGS

This is the first full scope market conduct examination performed on the Company by the TDCI; thus there are no previous examination findings.

HISTORY AND PROFILE

The Company was originally incorporated as the Tennessee Hospital Service Association under a charter dated September 10, 1945. The Company was organized under authority, terms and provisions of Chapter 98 of the Public Acts of Tennessee of 1945 which governed the organization and conduct of nonprofit hospital service companies.

On June 9, 1949, the Company filed an amendment to its charter and was granted authority by the State of Tennessee to provide medical expense indemnity benefits.

On November 29, 1968, the Company filed an amendment to its charter with the State of Tennessee to have its named changed to Blue Cross-Blue Shield of Tennessee and later to Blue Cross and Blue Shield of Tennessee on April 8, 1974. On May 10, 1972, the Company filed an amendment with the State of Tennessee to expand its services to establish and operate a dental service plan, to operate a vision service plan and to furnish and to administer such other services and plans, either along or in conjunction with one (1) or more governmental agencies or other organizations, as may from time to time become available, all on a voluntary, nonprofit basis.

On February 23, 1981, the members approved an amendment to the charter which redefined the composition of the Board of Trustees. The amendment became effective January 12, 1982. The bylaws were revised to incorporate the charter amendment effective September, 1981. A charter amendment filed with the Tennessee Secretary of State on May 29, 1985, changed the address of the principal office of the Company to Blue Cross Building, 801 Pine Street, Chattanooga, Tennessee, 37402.

Effective January 1, 1996, the Company entered into an agreement to affiliate/combine with Memphis Hospital Service and Surgical Association ("MHSSA") of Memphis, Tennessee. Under the terms of the affiliation agreement, a holding company was formed for the purpose of serving as the sole member in the Company and in MHSSA. In

connection with the affiliation, the Company changed its name to Chattanooga Hospital and Medical Service Association and the holding company became Blue Cross and Blue Shield of Tennessee.

On December 4, 1998, the directors of MHSSA and Blue Cross and Blue Shield of Tennessee voted to merge with and into Chattanooga Hospital and Medical Service Association, with Chattanooga Hospital and Medical Service Association being the surviving entity. The merger became effective on January 1, 1999, with Chattanooga Hospital and Medical Service Association changing its name to BlueCross BlueShield of Tennessee, Inc.

PERTINENT FACTUAL FINDINGS

A. COMPANY OPERATIONS AND MANAGEMENT

Comments:
The evaluation of standards in this business area is based on a review of Company responses to information requests, questions, interviews, and presentations made to the examiner. This portion of the examination is designed to provide a view of how the Company is structured and how it operates and is not based on sampling techniques. Many troubled companies have become so because management has not been structured to adequately recognize and address problems that can arise. Well run companies generally have processes that are similar in structure. While these processes vary in detail and effectiveness from company to company, the absence of them or the ineffective application of them is often reflected in failure of the various standards tested throughout the examination. The processes usually include:

- A planning function where direction, policy, objectives and goals are formulated;
- An execution or implementation of the planning function elements;
- A measurement function that considers the results of the planning and execution; and
- A reaction function that utilizes the results of measurement to take corrective action or to modify the process to develop more efficient and effective management of its operations

Standard A 1 *NAIC Market Conduct Examiners Handbook - Chapter XVII, § A, Standard 1*
Review Methodology: Generic
The Company has an up-to-date, valid internal or external audit program.

Results:
Pass

Observations:
The Company maintains an internal audit department. The Company provided documentation for their internal and external audit program which included the "Audit

Plan Summary" and three (3) completed external audit reports performed during the years under review. The Company also has numerous audits that focus on data and information systems, claims system and internal control systems. Formal reports of audits are provided to responsible management at the conclusion of each audit. The Company has a valid audit program in place and the information produced is being used as a management tool. No exceptions were noted.

Recommendations:
None

Standard A 2	*NAIC Market Conduct Examiners Handbook - Chapter XVII, § A, Standard 2*
Review Methodology: Generic	
The Company has appropriate controls, safeguards and procedures for protecting the integrity of computer information.	

Comments:
This standard is primarily focused on whether the Company has a process for protecting computer information. Failure to provide appropriate protection may cause harm to members and may affect the Company's financial position.

Observations:
The Company has an information security program that provides processes for protection of information, central recovery and backup including business recovery, data network security and systems integrity. The plan and procedures for the protection of computer maintained information was deemed to be valid and up-to-date. No exceptions were noted.

Recommendations:
None

Standard A 3	*NAIC Market Conduct Examiners Handbook - Chapter XVII, § A, Standard 3*
Review Methodology: Generic	
The Company has antifraud initiatives in place that are reasonably calculated to detect, prosecute, and prevent fraudulent insurance acts.	*Tenn. Code Ann. §§ 56-53-109 & 56-53-111*

Comments:
This standard is primarily focused on whether the Company has a process for detection and prevention of fraud. Failure to provide an appropriate process may cause harm to members and may affect the Company's financial position.

Results:
Pass

Observations:
The Company has a written antifraud plan in place. The Company's Special Investigation Unit ("SIU") is responsible for administering the antifraud plan. Specifically, SIU is responsible for detecting, investigating, preventing and reporting

fraud. All new employees are provided training regarding fraud and abuse by the SIU staff during New Employee Orientation. The Company's Information Security Department and HIPAA Privacy Office have implemented security measures that meet thresholds to protect the Company. The Company has sufficient antifraud initiatives in place.

Recommendations:
None

Standard A 4 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § A, Standard 4*
Review Methodology: Generic
The Company has a valid disaster recovery plan.

Comments:
This standard is intended to assure the Company has procedures in place to remain functional in case of disaster. Failure to function may cause harm to members and may affect the Company's financial position.

Results:
Pass

Observations:
The Company has one hundred forty two (142) recovery teams to divide the recovery effort into the basic working units of the Company. Each team completes a recovery plan, and then each team develops specific recovery procedures and requirements unique to its specific function. Key contacts and other changing parts of the plan are updated every six (6) months. The Company also employs outside vendors for the backup of information and related systems. Disaster recovery plans were deemed adequate.

Recommendations:
None

Standard A 5 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § A, Standard 5*
Review Methodology: Generic
The Company is adequately monitoring the activities of the Managing General Agents, General Agents, Third Party Administrators or any entity that contractually assumes a business function or is acting on behalf of the company.

Tenn. Code Ann. §§ 56-6-402 (for Third Party Administrators) 56-6-504 and 56-6-505 (for Managing General Agents)

Comments:
This standard is intended to assure the Company has procedures in place to monitor third party administrators, general agents and managing general agents who assume a business function for the Company.

Results:
Pass

Observations:
The examiners reviewed the process for five (5) third party administrators employed during the examination period. The Company audits or inspects the books and records of

the administrators. The Company has procedures in place to monitor entities performing Company business functions. No exceptions were noted.

Recommendations:
None

Standard A 6	*NAIC Market Conduct Examiners Handbook – Chapter XVII, § A, Standard 6*
Review Methodology: Generic	
Records are adequate, accessible, consistent, orderly and comply with state record retention requirements.	
	Tenn. Code Ann. §§ 56-29-114, 56-1-411(b)(1) and Tenn. Comp. R. & Regs. 0780-1-20-.04

Comments:
This standard is intended to assure an adequate and accessible record exists of the Company's transactions. The focus is on the records and actions considered in a market conduct examination such as but not limited to, trade practices, claim practices, policy selection and issuance, rating, complaint handling, etc. Inadequate, disorderly, inconsistent, and inaccessible records can lead to inappropriate rates and other issues, which can provide harm to the public.

Results:
Pass

Observations:
Throughout the examination Company records and files were reviewed to determine if documentation supported the decisions made. Files and records were in compliance with this standard.

Recommendations:
None

Standard A 7	*NAIC Market Conduct Examiners Handbook – Chapter XVII, § A, Standard 7*
Review Methodology: Generic	
The Company is licensed for the lines of business that are being written.	
	Tenn. Code Ann §§ 56-2-105, 56-29-106, and 56-29-108

Comments:
This standard is intended to assure the Company's operations are in conformance with its certificate of authority.

Results:
Pass

Observations:
The lines of business written are consistent with the Company's certificate of authority as issued by the TDCI.

Recommendations:
None

Standard A 8	*NAIC Market Conduct Examiners Handbook – Chapter XVII, § A, Standard 8*
Review Methodology: Generic **The Company cooperates with examiners on a timely basis.**	
	Tenn. Code Ann. §§ 56-1-411(b)(1), 56-1-412, and 56-29-115

Comments:
This standard is aimed at assuring the Company is cooperating with the TDCI in the completion of an open and cogent review of the Company's operations in Tennessee. Cooperation with examiners in the conduct of an examination is not only required by Tennessee statute, it is conducive to completing the examination in a timely fashion and minimizing cost.

Results:
Pass

Observations:
The Company was cooperative and the examination proceeded in a cordial atmosphere. Data provided was responsive and timely.

Recommendations:
None

Standard A 9	*NAIC Market Conduct Examiners Handbook – Chapter XVII, § A, Standard 9*
Review Methodology: Generic **The Company has procedures for the collection, use and disclosure of information gathered in connection with insurance transactions so as to minimize any improper intrusion into the privacy of applicants and policyholders.**	
	Tenn. Code Ann. § 56-8-119 and Tenn. Comp. R. & Regs. 0780-1-72

Comments:
This standard is intended to assure the Company provides adequate protection of information it holds concerning its policyholders and minimizes any improper intrusion into the privacy of applicants and policyholders.

Results:
Pass

Observations:
The Company has procedures in place for the collection and use of information gathered and provided them for review. The Company maintains an appropriate "Notice of Privacy Practices" and provides a copy to consumers. The Company also provides consumers with pertinent disclosure authorization forms. No exceptions were noted.

Recommendations:
None

Standard A 10	*NAIC Market Conduct Examiners Handbook – Chapter XVII, § A, Standard 10*
Review Methodology: Generic **The Company has developed and implemented written policies, standards, and procedures for the management of insurance information.**	*Tenn. Code Ann. § § 56-1-411(b)(1) and (f), and 56-8-119 and Tenn. Comp. R. & Regs. 0780-1-72*

Comments:
This standard is intended to assure the Company provides adequate protection of information it holds concerning its policyholders and minimizes any improper intrusion into the privacy of applicants and policyholders.

Results:
Pass

Observations:
The Company was requested and did provide its privacy policies and procedures for the handling of insurance information. The procedures in place were deemed adequate for the handling, disclosing, storing and disposing of insurance information.

Recommendations:
None

Standard A 11	*NAIC Market Conduct Examiners Handbook – Chapter XVII, § A, Standard 11*
Review Methodology: Generic **The Company has policies and procedures to protect the privacy of nonpublic personal information relating to its customers, former customers and consumers who are not customers.**	*Tenn. Code Ann. § 56-8-119 and Tenn. Comp. R. & Regs. 0780-1-72*

Comments:
This standard is intended to assure the Company provides adequate protection of information it holds concerning its policyholders and minimizes any improper intrusion into the privacy of applicants and policyholders.

Results:
Pass

Observations:
The Company provided thirty (30) documents pertaining to Privacy Procedures. Procedures were for such areas as Consent, Authorization, Permitted Disclosures, Confidential communications, Members and personal representatives, Individual's rights, complaint procedures and privacy notices. In addition, the Company has adequate

procedures for employees regarding the treatment of nonpublic personal information. No exceptions were noted.

Recommendations:
None

Standard A 12 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § A, Standard 12*
Review Methodology: Generic
The Company provides privacy notices to its customers and, if applicable, to its consumers who are not customers regarding treatment of nonpublic personal financial information.

Tenn. Code Ann. § 56-8-119 and Tenn. Comp. R. & Regs. 0780-1-72

Comments:
This standard is intended to assure the Company provides notice to customers and consumers who are not customers about the treatment of nonpublic personal financial information.

Results:
Pass

Observations:
Privacy notices were reviewed and it was determined they contained appropriate content and were clear, conspicuous and reasonably understandable. The Company properly indicates the categories of nonpublic personal financial information it discloses. No exceptions were noted.

Recommendations:
None

Standard A 13 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § A, Standard 13*
Review Methodology: Generic
If the Company discloses information subject to an opt-out right, the Company has policies and procedures in place so that nonpublic personal financial information will not be disclosed when a consumer who is not a customer has opted out, and the Company provides opt-out notices to its customers and other affected consumers.

Tenn. Code Ann. § 56-8-119 and Tenn. Comp. R. & Regs. 0780-1-72

Comments:
This standard is intended to assure the Company provides adequate protection of information it holds concerning its policyholders and minimizes any improper intrusion into the privacy of applicants and policyholders.

Results:
Pass

Observations:

The Company is not required to provide customers and other affected consumers an opportunity to "opt out" of the process to disclose their nonpublic personal financial information to nonaffiliated third parties. The regulation provides for exceptions to the "opt-out" requirements and all Company disclosures of nonpublic personal financial information to nonaffiliated third parties fall under the exceptions. No exceptions were noted.

Recommendations:
None

Standard A 14 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § A, Standard 14*
Review Methodology: Generic
The Company's procedures for the collection, use and disclosure of nonpublic personal financial information are in compliance with applicable statutes, rules and regulations.

Tenn. Code Ann. § 56-8-119 and Tenn. Comp. R. & Regs. 0780-1-72

Comments:
The standard has a direct insurance statutory requirement. This standard is intended to assure the Company provides adequate protection of information it holds concerning its policyholders and minimizes any improper intrusion into the privacy of applicants and policyholders.

Results: **Pass**

Observations:
The Company Privacy Notice and Privacy Operating Procedures were reviewed for compliance with Tenn. Comp. R. & Regs. 0780-1-72 to determine how nonpublic personal financial information received from a nonaffiliated financial institution is handled. The Company does not receive nonpublic personal financial information from nonaffiliated financial institutions.

Recommendations:
None

Standard A 15 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § A, Standard 15*
Review Methodology: Generic
Standard: Statutory
In states promulgating the health information provisions of the NAIC model regulation, or providing equivalent protection through other substantially similar laws under the jurisdiction of the Department of Insurance, the company has policies and procedures in place so that nonpublic personal health information will not be disclosed except as permitted by law, unless a customer or a consumer who is not a customer has authorized the disclosure.

Tenn. Code Ann. § 56-7-124

Comments:

This standard is intended to assure the Company provides adequate protection of information it holds concerning its policyholders and minimizes any improper intrusion into the privacy of applicants and policyholders.

Results:
Pass

Observations:
The Company provided their Privacy Operating Procedures which included procedures for securing authorizations from customers and consumers prior to disclosing nonpublic personal information. Procedures in place were deemed adequate.

Recommendations:
None

Standard A 16	*NAIC Market Conduct Examiners Handbook – Chapter XVII, § A, Standard 16*
Review Methodology: Generic	
Each licensee shall implement a comprehensive written information security program for the protection of nonpublic customer information.	*Tenn. Code Ann. § 56-8-119*

Comments:
This statute addresses protecting information but does not require a written security program. This standard is intended to assure the Company provides adequate protection of information it holds concerning its policyholders and minimizes any improper intrusion into the privacy of applicants and policyholders.

Results:
Pass

Observations:
The Company has a written information security program designed to ensure the security and confidentiality of customer information; and protect against any anticipated threats or hazards to the security or integrity of the information; and protect against unauthorized access to or use of the information that could result in substantial harm or inconvenience to any customer.

Recommendations:
None

B. COMPLAINT HANDLING

Comments:
Evaluations of the standards in this business area are based on Company responses to various information requests and review of complaint files at the Company. A random sample of fifty (50) files were selected using Audit Command Language ("ACL")

software from a population of seven hundred forty two (742). The Company should maintain a complete record of all the complaints which it has received since the date of its last examination. The definition of a complaint is "...any written communication primarily expressing a grievance."

Standard B 1	*NAIC Market Conduct Examiners Handbook – Chapter VIII, § B, Standard 1*
Review Methodology: Generic and Sample	
All complaints are recorded in the required format on the Company complaint register.	

Comments:
This standard is concerned with whether the Company keeps a formal record of complaints. An insurer is required to maintain a complete record of all complaints received. The record must indicate the total number of complaints received in the examination period, the classification of each complaint by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint.

Results:
Pass

Observations:
The Company utilized three (3) different systems for maintaining the TDCI complaint register during the period covered by this examination. The Company provided its list of TDCI complaints in three (3) separate data files. Consumer complaints submitted in writing directly to the Company are recorded and treated as grievances. Complaints received by telephone are referred to the Company's grievance process. Complaint registers contained the necessary information. No exceptions were noted.

Recommendations:
None

Standard B 2	*NAIC Market Conduct Examiners Handbook – Chapter VIII, § B, Standard 2*
Review Methodology: Generic	
The Company has adequate complaint handling procedures in place and communicates such procedures to policyholders.	

Comments:
This standard is concerned with whether the Company has adequate complaint handling procedures and whether the Company communicates complaint handling procedures to its policyholders.

Results:
Pass

Observations:
The Company does not have written procedures for handling complaints received from the TDCI. The Company provided a flow chart of the process for handling TDCI

complaints. The flowchart provides a process for providing a response to the TDCI. The flowchart includes the production of monthly reports for management. The flow chart was deemed adequate for handling complaints and provides enough detail to analyze areas developing complaints and to respond to complaints timely.

Recommendations:
None

Standard B 3 *NAIC Market Conduct Examiners Handbook – Chapter VIII, § B, Standard 3*
Review Methodology: Sample
The Company should take adequate steps to finalize and dispose of the complaint in accordance with applicable statutes, rules and regulations and contract language.

Comments:
This standard is concerned with whether the Company took adequate steps to finalize or resolve all issues raised in complaint inquiries.

Results:
Pass

Observations:
Complaint files were reviewed to determine if the Company took adequate steps to finalize the issues raised in the complaint and if file documentation supported the decisions made. Complaints issues were resolved and file documentation supported the decisions made. No exceptions were noted.

Table B3 Finalize Complaint

Type	Sampled	N/A	Pass	Fail	% Pass
Complaint Finalized	50	0	50	0	100%

Recommendations:
None

Standard B 4 *NAIC Market Conduct Examiners Handbook – Chapter VIII, § B, Standard 4*
Review Methodology: Sample
Standard: Statutory
The time frame within which the Company responds to complaints is in accordance with applicable statutes, rules and regulations.
Tenn. Code Ann. § 56-1-106

Comments:
This standard is concerned with whether the Company responded to complaints timely. Tennessee's complaint handling section requires a thirty (30) calendar day standard for responses to complaints.

Results:
Pass with recommendation

Observations:
The examination included a review of fifty (50) complaints received by the TDCI. The Company failed to respond timely to TDCI regarding five (5) complaints as required by Tenn. Code Ann. § 56-1-106(a).

Table B4 Timely Response

Type	Sampled	N/A	Pass	Fail	% Pass
Complaint Response Time	50	0	45	5	90%

Recommendations:
It is recommended the Company adopt and implement written procedures in accordance with Tenn. Code Ann. § 56-1-106(a), which requires a written response to the TDCI within thirty (30) calendar days

Standard B 5 *NAIC Market Conduct Examiners Handbook – Chapter VIII, § B, Standard 5*
Review Methodology: Sample
Determine if the underlying issue of the complaint is in compliance with applicable statutes, rules and regulations.

Comments:
This standard is concerned with whether the issue raised in the complaint was in violation of any statute, rule or regulation.

Results:
Pass

Observations:
The examination included a review of fifty (50) complaints received by the TDCI. The underlying issues of the complaints were determined to be in compliance with the statutes, rules and regulations.

Table B5 Complaint Issue

Type	Sampled	N/A	Pass	Fail	%Pass
Complaint Issues	50	0	50	0	100%

Recommendations:
None

C. GRIEVANCE PROCEDURE

Comments:
Evaluations of the standards in this business area are based on Company responses to various information requests and review of grievance files at the Company. The grievance procedures portion of the examination is designed to evaluate how well the company handles grievances. The NAIC definition of a grievance is shown in Standard C 1.

Standard C 1 *NAIC Market Conduct Examiners Handbook – Chapter VIII, § C, Standard 1*
Review Methodology: Generic
The health carrier treats as a grievance any written complaint submitted by or on behalf of a covered person regarding: (1) the availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (2) claims payment, handling, or reimbursement for health care services; or (3) matters pertaining to the contractual relationship between a covered person and the carrier.

Comments:
This standard is concerned with whether the Company correctly handles grievances submitted by covered persons.

Results:
Pass

Observations:
The Company definition of a grievance is broader than that of the NAIC. The Company treats all written complaints as grievances. When an oral complaint is made by a complainant with the customer service representative ("CSR"), the CSR will attempt to resolve the issue at that time. If the issue cannot be resolved, the CSR will inquire if the complainant wishes to file a grievance regarding the issue. A form is mailed to the complainant to be completed and returned to the Company.

Recommendations:
None

Standard C 2 *NAIC Market Conduct Examiners Handbook – Chapter VIII, §C, Standard 2*
Review Methodology: Generic
The health carrier documents grievances and establishes, and maintains grievance procedures in compliance with statute, rules, and regulations.

Comments:
This standard is concerned with whether the Company has adequate grievance handling procedures and whether the Company communicates grievance procedures to its policyholders. A health carrier shall maintain a grievance register consisting of written records to document all grievances received during a calendar year.

Results:
Pass

Observations:
The Company has written procedures for receiving, processing and resolving grievances. The Company includes a description of its grievance procedures in the member certificates or policies. The Company recorded grievances for the examination period in an electronic database. Company practices and procedures were in compliance with this standard.

Recommendations:
None

Standard C 3	*NAIC Market Conduct Examiners Handbook – Chapter VIII, § C, Standard 3*
Review Methodology: Sample	
A health carrier files with the commissioner a copy of its grievance procedures, including all forms used to process a grievance.	

Comments:
This standard is concerned with whether the Company has grievance procedures and those procedures are filed with the Department of Commerce and Insurance.

Results:
Not Applicable – See explanation under observations.

Observations:
This procedure is not applicable as the grievance procedures are not required to be filed with the TDCI.

Recommendations:
None

Standard C 4	*NAIC Market Conduct Examiners Handbook – Chapter VIII, § C, Standard 4*
Review Methodology: Sample	
The health carrier conducts first level reviews of grievances in compliance with statutes, rules, and regulations.	

Comments:
The standard does not have a direct statutory requirement. This standard is concerned with the timely handling of first level grievances.

Results:
Pass

Observations:
Guidelines set forth by the NAIC require a health carrier to conduct a first-level review of all submitted grievances and issue a written decision within twenty (20) working days of receiving the grievance. Tennessee statutes and TDCI rules and regulations are silent regarding time constraints of grievance handling. In the absence of statutes, rules and regulations, Company guidelines were used for testing. The Company guidelines are based on and agree with policy language.

Per Company guidelines, grievances will be resolved as follows:

Urgent Care grievances will be resolved within 72 hours
Pre-service grievances will be resolved within 30 days
Post-service grievances will be resolved within 60 days

Recommendations:
None

Standard C 5	*NAIC Market Conduct Examiners Handbook – Chapter VIII, §C, Standard 5*
Review Methodology: Generic	
The health carrier conducts second level reviews of grievances in accordance with statutes, rules, and regulations.	

Comments:
The standard does not have a direct statutory requirement. This standard is concerned with the handling of second level grievances.

Results:
Pass

Observations:
The Company has procedures for Level II grievance procedures if the member is not satisfied with the results of the Level I grievance. The Company provided at least fifteen (15) working days advance notice of the hearing. The covered person has the right to appear in person at the Level II grievance hearing. The composition of the grievance committee is not specifically defined. Committee hearings are held in Chattanooga, Tennessee during normal business hours.

Recommendations:
None

Standard C 6	*NAIC Market Conduct Examiners Handbook – Chapter VIII, §C, Standard 6*
Review Methodology: Generic	
The health carrier handles grievances involving adverse utilization review determinations in compliance with statutes, rules, and regulations.	

Comments:
The standard does not have a direct statutory requirement. This standard is concerned with the timely handling of appeals of adverse utilization review decisions.

Results:
Pass

Observations:
The Company has a written program for Utilization Management. The Utilization Management program contains procedures for appeals of adverse utilization review determinations.

Recommendations:
None

Standard C 7	*NAIC Market Conduct Examiners Handbook – Chapter VIII, §C, Standard 7.*
Review Methodology: Generic	
The health carrier has procedures for and conducts expedited appeals in compliance with statutes, rules, and regulations.	

Comments:
The standard does not have a direct statutory requirement. This standard is concerned with the handling of requests for expedited appeals.

Results:
Pass

Observations:
The Company's procedures are to complete and notify the member of the findings of an expedited or urgent care review within the seventy-two (72) hour time frame as required under the policy language The Company's procedures are in compliance with this standard.

Recommendations:
None

D. MARKETING AND SALES

Comments:
The evaluation of standards in this business area is based on review of Company responses to information requests, questions, interviews and presentations made to the examiner. This portion of the examination is designed to evaluate the representations made by the Company about its products. The review is not typically based on sampling techniques but can be. The areas to be considered in this review include all media (radio, television, videotape, etc.), written and verbal advertising and sales materials.

Standard D 1	*NAIC Market Conduct Examiners Handbook - Chapter XVII, § D, Standard 1*
Review Methodology: Generic	
Standard: Statutory	
All advertising and sales materials are in compliance with applicable statutes, rules and regulations.	
	Tenn. Code Ann. §§ 56-8-101 & 56-8-104(1) and Tenn. Comp. R. & Regs. 0780-1-8

Comments:
This standard is intended to assure compliance with the prohibitions on misrepresentation. The review is concerned with all forms of media (print, radio, television, internet, etc.).

Results:
Pass

Observations:
The Company provided eighty-three (83) advertising pieces that included print ads, billboard ads, radio scripts, television scripts, yellow page ads and brochures. The Company also provided in hardcopy format downloaded from the agent/broker section of the Company website, samples of brochures and pamphlets used by producers in solicitation of sales of the Company's products. Advertising on the Company website was also reviewed.

The majority of the Company's advertising consists of "invitation to inquire" ads designed to generate interest in health insurance coverage and prompt prospective customers to contact the Company or an agent for more information. The Company does no "invitation to contract" advertising. Specific references or identification of policy benefits, costs, exceptions or limitations are not included in the advertising used by the Company.

All advertising and marketing materials reviewed were in compliance with Tenn. Code Ann. §§ 56-8-101, *et seq.*, Unfair Competition and Unfair or Deceptive Practices.

Table D1 Marketing and Sales Results

Type	Sampled	N/A	Pass	Fail	% Pass
Marketing Material	83	0	83	0	100%

Recommendations: **None**

Standard D 2 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § D, Standard 2*
Review Methodology: Generic and Sample
Company internal producer training materials are in compliance with applicable statutes, rules and regulations.

Comments:
Review methodology for this standard is generic and sample. This standard is intended to assure compliance with the prohibitions on misrepresentation and is specifically concerned with training or instructional representations made by the Company to its producers.

Results:
Pass with recommendation

Observations:
The review of this standard involved the review of training materials and communications to Company producers. The material was reviewed for violations and misrepresentation.

The Company provided producer training materials and all written and electronic communications to producers for review including:

- Agent/Broker Guide for Group Products
- Individual Products Agents Guide

- Agent Advertising and Promotion Guidelines
- Agent Guidelines for Product Literature
- Individual Products Sales Aids
- Agendas for Agent/Producer Training Meetings and Seminars

According to the individual producer training materials reviewed, agents/brokers are paid "no commissions" for HIPAA products, referred to as "Guaranteed Issue" products by the Company. Commission addendums also indicate no commissions are paid on "Guaranteed Issue" products.

The practice of offering commissions to producers for solicitation and sale of HIPAA related products in the individual market at a rate below commission levels for standard individual health products has been determined by CMS, formerly Health Care Financing Administration ("HCFA"), to be an act that "constitutes a circumvention of the insurance reform provisions of HIPAA." This determination was communicated to State insurance commissioners and insurance issuers in program memorandum 98-01 dated March 1998.

Recommendations:
It is recommended the Company comply with HIPAA provisions that require commission levels for the sale of products to applicants with less favorable risk characteristics not be at levels below those paid for sales of products to applicants with more favorable risk characteristics.

Standard D 3 *NAIC Market Conduct Examiners Handbook - Chapter XVII, § D, Standard 3*
Review Methodology: Generic
Company communications to producers are in compliance with applicable statutes, rules and regulations.

Comments:
This standard is aimed at assuring compliance with the prohibitions on misrepresentation. It is concerned with representations made by the Company to its producers through communications.

Results:
Pass

Observations:
The examiner received samples of electronic bulletins that are broadcast to producer on a regular basis and reviewed them in accordance with applicable Tennessee statutes, rules and regulations. There are no applicable statutes regarding communications between the Company and producers.

Standard D 4 *NAIC Market Conduct Examiners Handbook - Chapter XVII, § D, Standard 4*
Review Methodology: Generic
Standard: Statutory
Outlines of coverage are in compliance with applicable statutes, rules and regulations.

Tenn. Code Ann. §§ 56-26-108 and 56-26-125

and § 56-26-109

Comments:
This standard is aimed at assuring compliance with the prohibitions on misrepresentation. It is concerned with representations made by the Company to its members through outlines of coverage.

Results:
Pass

Observations:
Evidences (Outlines) of Coverage were reviewed for adherence to the above criteria and no exceptions were noted.

Recommendations:
None

Standard D 5 *NAIC Market Conduct Examiners Handbook - Chapter XVII, § D, Standard 5*
Review Methodology: Generic
Company has suitability standards for its products when required by applicable statutes, rules and regulations.

Comments:
This standard does not have a direct statutory requirement. This standard is aimed at assuring the Company has guidelines to determine suitability and limit multiple sales of similar products to individuals.

Results:
Pass

Observations:
A review of the policyholder listing did not indicate multiple issues of the same products to the same individuals. The underwriting guidelines contain no procedures that impose limitations of multiple sales to the same individuals. The Company includes in it's individual health policy an "Overinsurance Termination Provision" designed to acquire insurance information and to prevent overinsurance.

Recommendations:
None

E. NETWORK ADEQUACY

Comments:
Evaluations of the standards in this business area are based on Company responses to various information requests and review of Company policies and procedures. The network adequacy portion of the examination is designed to assure that companies

offering managed care plans maintain service networks that are sufficient to assure that all services are accessible without unreasonable delay. The standards require companies to assure the adequacy, accessibility, and quality of health care services offered through their service networks.

The areas to be considered in this kind of review include Company access plans and other measures used by the Company to analyze network sufficiency, contracts with participating providers and intermediaries, and on-going oversight and assessment of access issues.

Standard E 1	*NAIC Market Conduct Examiners Handbook – Chapter VIII, § E, Standard 1*
Review Methodology: Generic	
The health carrier demonstrates, using reasonable criteria, that it maintains a network that is sufficient in number and types of providers to assure that all services to covered persons will be accessible without unreasonable delay.	

Comments:
The standard does not have a direct statutory requirement. This standard is concerned that the Company has set reasonable criteria and standards by which the adequacy of its provider networks is assessed that assures all services are accessible without unreasonable delay.

Results:
Pass

Observations:
The Company assesses the adequacy of their network on a semi-annual basis. The Company provided copies of their "Network Assessments" for the examination period. Results are arranged by network, then by region and then by county. In addition, the Company provided information related to appointment wait times, hours of operation, etc. Network Assessment materials were reviewed to determine if they contain sufficient evidence of adequate ratios of providers to members and reasonable geographic accessibility to providers by county and specialty. A review of provider contracts, provider administration manual and the detailed "Quality Improvement Program" indicates providers are required to comply with specific requirements related to access during and after office hours, appointment wait times and other provisions related to member relations.

It appears the Company has a network in place sufficient in size and the Company monitors the effectiveness of the network. A review of the materials related to the Company's program to assess the adequacy of its provider networks shows that the Company, through use of "GeoAccess" geocoding software, adequately ensures that its members have access to network providers.

Recommendations:

None

Standard E 2	*NAIC Market Conduct Examiners Handbook – Chapter VIII, § E, Standard 2*
Review Methodology: Generic	
The health carrier files an access plan with the Commissioner for each managed care plan that the carrier offers in the state, and files updates whenever it makes a material change to an existing managed care plan The carrier makes the access plans available: 1) on its business premises 2) to regulators; and 3) to interested parties absent proprietary information upon request.	

Comments:
The standard does not have a direct statutory requirement.

Results:
Not Applicable – See explanation under observations.

Observations:
The Company is not required to file an access plan with the Commissioner of TDCI.

Recommendations:
None

Standard E 3	*NAIC Market Conduct Examiners Handbook – Chapter VIII, § E, Standard 3*
Review Methodology: Generic	
The health carrier files with the Commissioner all required contract forms, and any material changes to a contract, proposed for use with its participating providers and intermediaries. *Tenn. Code Ann. SS 56-29-107(3), 56-29-118*	

Comments:
Contracts with participating hospitals are to be filed with the Commissioner upon application for a license, with licenses to be renewed annually.

Results:
Not Applicable – See explanation under observations.

Observations:
Initial filings of contracts are required upon application for license, i.e. annual renewals. There are no requirements for filing material changes to contracts.

Recommendations:
None.

Standard E 4	*NAIC Market Conduct Examiners Handbook – Chapter VIII, § E, Standard4*
Review Methodology: Generic	
The health carrier ensures covered persons have access to emergency services twenty-four (24) hours per day, seven (7) days per week within its network and provides coverage for emergency services outside of its network.	
	Tenn. Code Ann. § 56-7-2355

Comments:
This statute is to prevent denial of coverage for emergency services by health benefit plan. It does not address 24/7 access to amergency services. Tenn. Code Ann. §§ 56-7-2356 has provisions for 24/7 emergency care, however it applies only to HMOs and all closed networks. BlueCross must compy only if they sell a closed network product.

Results:
Pass

Observations:
The examiner reviewed sample insurance policies and the provider administration manual to determine if the Company covers necessary emergency services. Member policies contain provisions that in the event of the need for emergency care, no pre-authorization is required and benefits for emergency care from out-of-network facilities are paid at the same level as emergency care from a participating facility. In addition, the Company's provisions for an acute care facility's (hospital) network participation include the requirement of a license from the State and the requirements for obtaining the hospital license includes the maintaining of an emergency department. The Company policies ensure coverage for emergency services twenty-four (24) hours per day, seven (7) days per week.

Recommendations:
None

Standard E 5 *NAIC Market Conduct Examiners Handbook – Chapter VIII, § E, Standard 5*
Review Methodology: Generic
The health carrier executes written agreements with each participating provider that are in compliance with statutes, rules, and regulations.

Tenn. Code Ann. § 56-29-116

Comments:
The statute requires that hospitals must be approved by the Commissioner. This standard is concerned that the Company has valid agreements in place with participating providers. **There is no direct statutory requirement for the content of the agreements.**

Results:
Pass

Observations:
The physician and institution agreements were reviewed to determine compliance with Tennessee statute. The agreements contain a "hold harmless" provision which restricts the providers with respect to recourse against members for payment for covered services. The provider contracts reviewed do contain provisions to ensure the continuation of coverage in the event of contract termination. Agreements are in compliance with this standard.

Recommendations:
None

Standard E 6	*NAIC Market Conduct Examiners Handbook – Chapter VIII, § E, Standard 6*
Review Methodology: Generic	
The health carrier's contracts with intermediaries are in compliance with statutes, rules, and regulations.	
	Tenn. Code Ann. §§ 56-6-401, et seq.

Comments:
There is a direct statutory requirement as stated above, but it will not apply here if they do not use any intermediaries (TPAs). This standard is concerned that the Company has valid agreements in place with intermediaries or other third party entities performing a business function for the Company.

Results:
Not Applicable – See explanation under observations.

Observations:
The Company contracts directly with participating providers The Company used no intermediaries.

Recommendations:
None

Standard E 7	*NAIC Market Conduct Examiners Handbook – Chapter VIII, § E, Standard 7*
Review Methodology: Generic	
The health carrier's arrangements with participating providers comply with statutes, rules, and regulations.	

Comments:
The standard does not have a direct statutory requirement. This standard is concerned that the provider arrangements are valid and do not affect quality of service to members.

Results: **Pass**

Observations:
The Company makes available to providers through their website detailed information related to provider responsibility to provide specific services as well as detailed communications related to updates in Company medical policy, billing and administrative changes.

Recommendations:
None

Standard E 8	*NAIC Market Conduct Examiners Handbook – Chapter VIII, § E, Standard 8*
Review Methodology: Generic	
The health carrier provides at enrollment a Provider Directory listing all providers participating in its network. It also makes available, on a timely and reasonable basis, updates to its directory.	

Comments:
The standard does not have a direct statutory requirement. This standard concerns the Company making the provider list available to members.

Results:
Pass

Observations:
It was determined the Company updates the online version of the provider directories on a daily basis. Hard copy versions of the updates of provider directories are provided twice per year and to new issues and renewals or upon request.

Recommendations:
None

F. PRODUCER LICENSING

Comments:
The evaluation of these standards is based on review of the TDCI Commissioner's files, and Company responses to information requests, questions, interviews, and presentations made to the examiner. This portion of the examination is designed to test the Company's compliance with Tennessee producer licensing statutes and rules. The Tennessee Insurance Producer Licensing Act of 2002, ("the Act") contains various requirements for the Company to contract only with producers that are properly licensed to solicit business for the lines of business sold. The Act also requires the Company to properly appoint each producer with whom the Company transacts business and to properly terminate that appointment when the producer is no longer authorized to transact business with the Company. The Act also contains requirements for specific reporting to the TDCI of all producer appointments and terminations.

Standard F 1	*NAIC Market Conduct Examiners Handbook – Chapter XVII, § F, Standard 1*
Review Methodology: Sample	
Standard: Statutory	
Company records of licensed and appointed producers agree with department of insurance records.	
	Tenn. Code Ann. §§ 56-6-115(c) – (d) and 56-6-117(a), (b), and (d)

Comments:
This standard is aimed at assuring compliance with the requirement that producers be properly licensed and appointed.

Results:
Pass

Observations:
The examiners requested and received from the Company a list of producers appointed during the examination period. A sample of twenty-five (25) producer records was tested to determine if appointment dates corresponded with those recorded by the TDCI. All producers were properly appointed. No discrepancies were detected.

Recommendations:
None

Standard F 2	*NAIC Market Conduct Examiners Handbook – Chapter XVII, § F, Standard 2*
Review Methodology: Generic	
Standard: Statutory	
The producers are properly licensed and appointed (if required by state law) in the jurisdiction where the application was taken.	
Tenn. Code Ann. §§ 56-6-103, 56-6-107, 56-6-111, 56-6-113, 56-6-115, 56-6-117, 56-6-118 and 56-6-108	

Comments:
This standard is aimed at assuring compliance with the requirement that producers be properly licensed and appointed for business solicited in Tennessee.

Results:
Pass with recommendation

Observations:
Agency producers, independent producers and staff sales executives perform solicitations and sales of Company products. Producer compensation is primarily comprised of commissions, except for direct sales by staff sales executives, which are salaried Company employees. In the review of twenty-five (25) producer files, one (1) producer was found to have sold one (1) policy before the effective date of the appointment. Selling policies on behalf of the Company before the appointment date violates Tenn. Code Ann. § 56-6-115. Two (2) sampled producer files lacked evidence of current insurance license. Appointment of producers and producer sales of insurance without a current license is a violation of Tenn. Code Ann. §§ 56-6-103, 56-6-106 and 56-6-115.

Table F2 Producer License

Type	Sampled	N/A	Pass	Fail	% Pass
Producer Files	25	0	23	2	92%

In addition, two (2) sampled producer files lacked evidence of Errors and Omissions coverage as required by the Company for appointment.

Recommendations:
(a) It is recommended the Company adopt and implement procedures to ensure producers are properly licensed and appointed prior to negotiation or solicitation of business.

(b) It is recommended the Company adopt and implement procedures to ensure producers evidence Errors and Omissions coverage prior to appointment.

Standard F 3 *Market Conduct Examiners Handbook – Chapter XVII, § F, Standard 3*
Review Methodology: Sample
Standard: Statutory
Termination of producers complies with statutes regarding notification to the producer and notification to the state if applicable.

Tenn. Code Ann. § 56-6-117

Comments:
This standard is aimed at both avoiding unlicensed placements of insurance as well as ensuring that producers are treated fairly with respect to terminations. Tenn. Code Ann. § 56-6-117 requires the Company to notify the Commissioner within thirty (30) days of terminating a producer's authority. The same code section further requires the producer to be notified within fifteen (15) days of the notice to the Commissioner of TDCI.

Results:
Fail

Observations:
A sample of twenty-five (25) producer files terminated during the examination were requested for review. The Company could not provide any records on four (4) terminated producers and could only produce partial records on two (2) additional producers in the sample of terminated producers. In complete files, the Company failed to send terminated producers and the TDCI written notification of termination in five (5) cases as required by Tenn. Code Ann. § 56-6-117(e)(1).

Table F3 Producer License

Type	Sampled	N/A	Pass	Fail	% Pass
Producer termination notification	25	0	14	11	56%

Recommendations:
It is recommended the Company maintain accurate and complete records of terminated producers and provide written notice to terminated producers and the TDCI as required by Tenn. Code Ann. §§ 56-6-117.

Standard F 4 *NAIC Market Conduct Examiners Handbook– Chapter XVII, § F, Standard 4*
Review Methodology: Generic
Standard: Statutory
The Company's policy of producer appointments and terminations does not result in unfair discrimination against policyholders.

Tenn. Code Ann. § 56-8-104(6) and Tenn. Comp. R. & Regs. 0780-1-34

Comments:
This standard is intended to ensure producer appointments and terminations do not result in unfair discrimination against policyholders.

Results:
Pass

Observations:
The Company's guidelines and procedures for appointing and terminating agents along with its marketing plan were reviewed for adherence to this standard without exception.

Standard F 5	*Market Conduct Examiners Handbook – Chapter XVII, § F, Standard 5*
Review Methodology: Sample	
Standard: Statutory	
Records of terminated producers adequately document reasons for terminations.	
	Tenn. Code Ann. § 56-6-117

Comments:
This standard is intended to aid in the identification of producers involved in unprofessional behavior, which is harmful to the public.

Results:
Fail

Observations:
The Company could not provide any records on four (4) terminated producers. The remaining twenty-one (21) producer files adequately documented reasons for termination. One (1) termination was for cause and the TDCI was properly notified.

Table F5 Producer License

Type	Sampled	N/A	Pass	Fail	% Pass
Producer termination notification	25	0	21	4	84%

Recommendations:
It is recommended the Company maintain accurate and complete records of terminated producers.

Standard F 6	*NAIC Market Conduct Examiners Handbook – Chapter XVII, § F, Standard 6*
Review Methodology: Sample	
Debit producer accounts current (account balances) are in accordance with the producers' contract with the insurer.	

Comments:
This standard is intended to aid in the identification of producers involved in unprofessional behavior, which is harmful to the public.

Results:
Pass

Observations:

The commission statements of the sampled producers were reviewed for the period under examination. Commissions were recalculated to determine that they were paid in accordance with the Company commission schedules without exception.

Recommendations:
None

G. PROVIDER CREDENTIALING

Comments:
Evaluations of the standards in this business area are based on Company responses to various information requests and review of Company policies and procedures. The purpose of the review of provider credentialing is to determine if the Company has established a formal and effective program to verify credentials of practitioners and other health care providers as a way of evaluating and ensuring the delivery of quality services.

Standard G 1 *NAIC Market Conduct Examiners Handbook – Chapter VIII, §G, Standard 1*
Review Methodology: Generic
The health carrier establishes and maintains a program for credentialing and re-credentialing in compliance with statues, rules, and regulations.

Comments:
The standard does not have a direct statutory requirement. This standard is aimed at verifying the Company has a valid credentialing program in place that protects members and is fair to providers.

Results:
Pass

Observations:
The Board of Directors delegates the oversight of the credentialing function to the Clinical Risk Management Committee ("CRMC") for authorization of all credentialing activities. The CRMC delegates peer review responsibilities and final acceptance of provider credentialing status to the Credentialing Committee.

The Credentialing Committee reports to the CRMC. The initial credentialing and re-credentialing process defines proper documentation to support the committee in its determination whether practitioners and other health care providers meet certain standards.

The Credentialing Committee is a peer review body that evaluates practitioners and other health care providers' credentials, clinical skills and professional conduct. The Credentialing Committee is responsible for evaluating, final acceptance, deferment (for more information), or denial of practitioners and other health care providers. The Company has established a valid program for the credentialing of health care providers.

Recommendations:
None

Standard G 2	*NAIC Market Conduct Examiners Handbook – Chapter VIII, § G, Standard 2*
Review Methodology: Generic	
The health carrier verifies the credentials of a health care professional before entering into a contract with that health care professional.	

Comments:
The standard does not have a direct statutory requirement. This standard is concerned with whether the Company completes the credentialing process prior to entering into an agreement with provider.

Results: **Pass**

Observations:
The Company has written procedures in place that require the credentialing process be complete before contracting with a provider. The Company provided documentation to ensure that credentialing was completed before a provider appeared in the provider directory.

Recommendations:
None

Standard G 3	*NAIC Market Conduct Examiners Handbook – Chapter VIII, § G, Standard 3*
Review Methodology: Generic	
The health carrier obtains primary verification of the information required by (state provision equivalent to the Health Care Professional Verification Act).	

Comments:
The standard does not have a direct statutory requirement. This standard is concerned with the Company's involvement with the credentialing process.

Results:
Pass

Observations:
The Company credentialing process includes the primary verification of information including the following:

Current license, certificate of authority or registration to practice in the State;
Current level of professional liability coverage;
Status of hospital privileges;
Specialty board certification status;
Current Drug Enforcement Agency ("DEA") registration certificate;
Graduation from health care professional school; and
Completion of post graduate training.

The Company's primary verification of information in the credentialing process meets standards established by the NAIC.

Recommendations:
None

Standard G 4 *NAIC Market Conduct Examiners Handbook – Chapter VIII, § G, Standard4*
Review Methodology: Generic
The health carrier obtains, through either a primary or secondary credentialing verification process, the information required by the TDCI.

Comments:
The standard does not have a direct statutory requirement. This standard is concerned with the Company's review of the health care provider's professional history.

Results:
Pass

Observations:
The Company has policies and procedures in the credentialing process to verify the following pertinent history:

1. The health care professional's license history in all states
2. The health care professional's malpractice history
3. The health care professional's practice history

The procedures in place satisfy the standards set forth by the NAIC.

Recommendations:
None

Standard G 5 *NAIC Market Conduct Examiners Handbook – Chapter VIII, § G, Standard 5*
Review Methodology: Generic
The health carrier obtains, at least every three (3) years, primary verification of the information required by the credentialing process.

Comments:
The standard does not have a direct statutory requirement. This standard is concerned that the Company maintains accurate and up to date credentialing information for providers.

Results: **Pass**

Observations: A review of the Company's credentialing policies and procedures indicates the verification of the information for credentialing takes place at least every three (3) years.

Recommendations:
None

Standard G 6	*NAIC Market Conduct Examiners Handbook – Chapter VIII, §G, Standard 6*
Review Methodology: Generic **The health carrier requires all participating providers to notify the health carrier's designated individual of changes in the status of any information that is required to be verified by the health carrier.**	

Comments:
The standard does not have a direct statutory requirement. This standard is concerned that the Company maintains accurate and up to date credentialing information for providers.

Results:
Pass

Observations:
In the "Physician Agreement" there is a section titled "Notification by Physician" by which providers are required to notify the Company of any changes that may affect their credentialing status.

Recommendations:
None

Standard G 7	*NAIC Market Conduct Examiners Handbook – Chapter VIII, § G, Standard 7*
Review Methodology: Generic **The health carrier provides a health care professional the opportunity to review and correct information submitted in support of that health care professional's credentialing verification.**	

Comments:
The standard does not have a direct statutory requirement. This standard is concerned that the Company treats providers fairly by allowing them the opportunity to review and correct information submitted in support of credentialing.

Results:
Pass

Observations:
The credentialing process is made available by the Company in the "Commercial Provider Administrative Manual" that is distributed on CD-ROM or can be downloaded at the Company website. Providers are afforded a process to appeal any information gathered by the Company in the credentialing process. The Company procedures in place allow providers to review and correct information gathered in the credentialing process.

Recommendations:

None

Standard G 8	*NAIC Market Conduct Examiners Handbook – Chapter VIII, §G, Standard 8*
Review Methodology: Generic	
The health carrier monitors the activities of the entity with which it contracts to perform credentialing functions.	

Comments:
The standard does not have a direct statutory requirement. This standard is concerned that the Company has proper oversight of third parties performing business functions.

Results:
Pass

Observations:
The Company does not employ a third party Credentialing Verification Organization.

Recommendations:
None

H. POLICYHOLDER SERVICES

Comments:
The evaluation of standards in this business area is based on review of Company responses to information requests, questions, interviews, and presentations made to the examiner and file sampling during the examination process. The policyholder service portion of the examination is designed to test a Company's compliance with Tennessee statutes regarding notice/billing, delays/no response, premium refund and coverage questions.

Standard H 1	*NAIC Market Conduct Examiners Handbook – Chapter XVII, § H, Standard 1*
Review Methodology: Generic, Sample and Electronic	
Premium notices and billing notices are sent out with an adequate amount of advance notice.	
	Tenn. Code Ann. §§ 56-7-2810; 56-7-2810

Comments:
There is no direct statutory requirement for billing. This standard is intended to provide insureds with information in a timely fashion so they can make informed decisions.

Results:
Pass

Observations:
In the review of individual and group underwriting files and guidelines, the examiner checked renewals to determine handling in accordance with applicable Tennessee

requirements. The Company offers its health products in the individual and small group markets on a guaranteed renewable basis, in accordance with Tennessee rules. The Company issued renewal notices forty-five (45) days prior to the effective date of the change. The procedures in place provided adequate advance notice. No exceptions were noted

Recommendations:
None

Standard H 2	*NAIC Market Conduct Examiners Handbook - Chapter XVII, § H, Standard 2*
Review Methodology: Generic	
Policy issuance and insured requested cancellations are timely.	
	Tenn Code Ann. §§ 56-26-108(3) and 56-26-109(8)

Comments:
There is no direct statutory requirement for policy issuance. Tennessee statute requires that cancellation is effective upon receipt. This standard is intended to provide insureds with information in a timely fashion so they can make informed decisions.

Results: **Pass with recommendation**

Observations:
A time study was performed to determine the number of days between application dates and coverage effective dates in the individual market. The average time was approximately twenty-four (24) days. In most cases, future effective dates were requested by applicants. In several cases, delays in issuance were due to incomplete applications. A time study was performed to determine the number of days between application dates and coverage effective dates in the small group market. The average time was sixteen (16) days.

The Company accepts cancellations of individual policies in writing or by verbal request to the Company or agent with thirty (30) days advance notice. Requests for cancellation of group agreements are accepted if provided with at least thirty-one (31) days prior notice. According to Tenn. Code Ann. § 56-26-109(8) after the policy has been continued after its original term, the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice.

Company procedures for policy issuance and insured requested cancellations are not in compliance with this standard.

Recommendations:
It is recommended that the Company amend its procedures to comply with the statutes.

Standard H 3	*NAIC Market Conduct Examiners Handbook - Chapter XVII, § H, Standard 3*

Review Methodology: Generic
All correspondence directed to the Company is answered in a timely and responsive manner by the appropriate department.

Tenn. Code Ann. § 56-8-104(8)

Comments:
Tenn. Code Ann. § 56-8-104(8) (A) discusses requirements for correspondence related to claims This standard is intended to ensure the Company is responsive to issues raised by applicants and insureds.

Results:
Pass

Observations:
During the review of the one hundred (100) underwriting files, correspondence from the insured was noted to determine if the Company responded timely. Company response to correspondence was deemed timely. No exceptions were noted.

Recommendations:
None

Standard H 4 *NAIC Market Conduct Examiners Handbook - Chapter XVII, § H, Standard 4*
Review Methodology: Generic
Reinstatement is applied consistently and in accordance with policy provisions.

Tenn. Code Ann. § 56-26-108(4)

Comments:
Tenn. Code Ann.§ 56-26-108(c) discusses the requirements for reinstatement. This standard is intended to ensure insureds are afforded appropriate reinstatement rights.

Results:
Pass

Observations:
To determine if the Company handles reinstatements appropriately and that reinstatement provisions are applied in a non-discriminatory manner, the examiner reviewed underwriting files for rescinded policies as well as policies terminated due to non-payment of premium. Where appropriate, coverage was reinstated back to the original date and notice was provided in a timely manner. The policy forms contain a description of the required provisions for reinstatement of policies. Reinstatement practices were in compliance with this standard.

Recommendations
None

Standard H 5 *NAIC Market Conduct Examiners Handbook - Chapter XVII, § H, Standard 5*

Review Methodology: Generic
Policy transactions are processed accurately and completely.

Comments:
There is no direct statutory requirement. This standard is intended to ensure policies are issued correctly

Results:
Pass

Observations:
During the review of the one hundred (100) underwriting files, the policies were reviewed to determine if coverage was issued as applied for. All policyholder requests were processed accurately and coverages were issued as applied for. No exceptions were noted.

Recommendations:
None

Standard H 6 *NAIC Market Conduct Examiners Handbook - Chapter XVII, § H, Standard 6*
Review Methodology: Generic
Non-forfeiture options are communicated to the policyholder and correctly applied in accordance with the policy contract.

Comments:
There is no direct statutory requirement. This standard is intended to ensure non-forfeiture options are correctly communicated and applied.

Results:
Not Applicable – See explanation under observations.

Observations:
Standard does not apply to Company products.

Recommendations:
None

Standard H 7 *NAIC Market Conduct Examiners Handbook - Chapter XVII, § H, Standard 7*
Review Methodology: Generic
Evidence of creditable coverage is provided in accordance with the requirements of HIPAA and/or statutes, rules, and regulations.
Tenn. Code Ann. § 56-7-2801 et seq.

Comments:
The focus of this standard is to assure portability of coverage. Tennessee statute is silent regarding the number of days a carrier has to distribute the Certificates of Creditable Coverage after the member termination date. Additionally, there is no requirement to

distribute a Certificate of Creditable Coverage to an insured being terminating from "individual" coverage.

Results:
Pass

Observations:
The Company provided the procedure for producing a certificate of "Creditable Coverage" when a member requested a copy. When individual coverage is cancelled, the computer system automatically produces a certificate of creditable coverage. Procedures in place were deemed adequate. No exceptions were noted.

Recommendations:
None

I. QUALITY ASSESMENT AND IMPROVEMENT

Comments:
Evaluations of the standards in this business area are based on Company responses to various information requests and the review of Company policies and procedures. The quality assessment portion of the examination is designed to assure that companies offering managed care plans have quality assessment programs in place that enable the company to evaluate, maintain, and, when required by Tennessee statutes, improve the quality of health care services provided to covered persons. For managed care plans that limit covered persons to a closed network, the standards also require a quality improvement program with specific goals and strategies for measuring progress toward those goals.

Standard I 1	*NAIC Market Conduct Examiners Handbook – Chapter VIII; SI, Standard 1*
Review Methodology: Generic	
The health carrier develops and maintains a quality assessment program in compliance with statutes, rules, and regulations.	

Comments:
The standard does not have a direct statutory requirement. This standard is aimed at verifying the Company has a valid quality assessment program in place for improving healthcare programs.

Results:
Pass

Observations:
The Company has a written Quality Assessment program titled "Quality Improvement Program," ("QIP"). The Program is administered by the Chief Medical Officer. The goal of the QIP is to support continuous improvement of safety of clinical care and the

quality of service through planned, systematic improvement activities. Some of the issues quality improvement is concerned with are:

Measure and analyze member and physician satisfaction;
Enhance member access and availability to providers;
Maintain preventive health practice guidelines;
Expand existing disease management programs;
Use results in credentialing and re-credentialing decisions; and
Monitor coordination of care among primary care practitioners and specialists.

It was determined the Company has a comprehensive Quality Improvement Plan in place and it is in compliance with NAIC standards.

Recommendations:
None

Standard I 2 *NAIC Market Conduct Examiners Handbook – Chapter VIII, § I, Standard 2*
Review Methodology: Generic
The health carrier files a written description of the quality assessment program with the Commissioner in the prescribed format, which shall include a signed certification by a corporate officer of the Company that the filing meets statutes, rules, and regulations.

Comments:
The standard does not have a direct statutory requirement. This standard is concerned with whether the Company has a written description of their quality assessment program and if it is filed with the TDCI.

Results:
Not Applicable – See explanation under observations.

Observations:
The Company is not required to file a copy or description of their QIP with the TDCI.

Recommendations: **None**

Standard I 3 *NAIC Market Conduct Examiners Handbook – Chapter VIII, § I, Standard 3*
Review Methodology: Generic
The health carrier develops and maintains a quality improvement program in compliance with statues, rules, and regulations.

Comments:
The standard does not have a direct statutory requirement. This standard is concerned that the QIP is valid and in compliance with applicable law.

Results:
Not Applicable – See explanation under observations.

Observations:
The Company has a comprehensive Quality Improvement Plan in place. However, there is no specific Tennessee statute or rule directly regulating Quality Improvement.

Recommendations: **None**

Standard I 4	*NAIC Market Conduct Examiners Handbook – Chapter VIII, § I, Standard4*
Review Methodology: Generic	
The health carrier reports to the appropriate licensing authority any persistent pattern of problematic care provided by a provider that is sufficient to cause the health carrier to terminate or suspend contractual arrangements with the provider.	

Comments:
The standard does not have a direct statutory requirement.

Results:
Pass

Observations:
For the examination period there were no providers terminated for problematic care. The Company has procedures in place in the credentialing process to detect problematic care.

Recommendations:
None

Standard I 5	*NAIC Market Conduct Examiners Handbook – Chapter VIII, § I, Standard 5*
Review Methodology: Generic	
The health carrier documents and communicates information about its quality assessment program and its quality improvement program to covered persons and providers.	

Comments:
The standard does not have a direct statutory requirement.

Results:
Pass

Observations:
A summary of quality improvement activities is communicated to staff, members, and practitioners at least annually through a standard newsletter. Upon request by members or practitioners, summary information related to the QIP is provided. When quality improvement activities result in health care practice recommendations, clinical practice guidelines or disease management programs, relevant information is distributed to members and practitioners

Recommendations:
None

Standard I 6	*NAIC Market Conduct Examiners Handbook – Chapter VIII, §I, Standard 6*
Review Methodology: Generic **The health carrier annually certifies to the Commissioner that its quality assessment and quality improvement program along with the materials provided to providers and consumers meet applicable requirements.**	

Comments:
The standard does not have a direct statutory requirement. This standard is concerned that the QIP is valid and in compliance with applicable statutes.

Results:
Not Applicable – See explanation under observations.

Observations:
The Company is not required to certify its QIP.

Recommendations:
None

Standard I 7	*NAIC Market Conduct Examiners Handbook – Chapter VIII, § I, Standard 7*
Review Methodology: Generic **The health carrier monitors the activities of the entity with which it contracts to perform quality assessment or quality improvement functions and ensures that the requirements are met.**	

Comments:
The standard does not have a direct statutory requirement. This standard is concerned that the Company has proper oversight of third parties performing business functions.

Results:
Not Applicable – See explanation under observations.

Observations:
The Company does not delegate QIPs to third parties.

Recommendations:
None

J. UNDERWRITING AND RATING

Comments:
The evaluation of standards in this business area is based on a review of Company responses to information requests, questions, interviews, presentations made to the examiner and file sampling. The underwriting and rating practices portion of the examination is designed to provide a view of how the Company treats the public and whether that treatment complies with applicable statutes and rules. A review of a sample of one hundred (100) randomly selected underwriting files, equally distributed among

individual business, small group business and large group business and included, but not limited to, verification of rating factors; accuracy of calculated premiums; completeness and accuracy of file documentation and appropriateness of policy issuance, declination, termination, rescission and non-renewal practices. The method used for the selection of the sample individual and group underwriting files for testing included using ACL software to randomly select samples of thirty-four (34), thirty-three (33) and thirty-three (33) from the populations of individual health, small group and large group underwriting files respectively.

Standard J 1 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § J, Standard 1*
Review Methodology: Sample
The rates charged for the policy coverage are in accordance with filed rates (if applicable) or the company rating plan.
Tenn. Code Ann. §§ 56-26-102,56-29-116 et seq. and Tenn. Comp R. & Regs. 0780-1-20

Comments:
It is necessary to determine if the Company complies with the rating systems that have been filed and approved by the TDCI. Wide scale application of incorrect rates by a company may raise financial solvency questions or be indicative of inadequate management oversight. Deviation from established rating plans may also indicate a company is engaged in unfair competitive practices.

Results:
Pass

Observations:
A review of rates and policy forms was performed to determine if the Company properly and timely files with the TDCI all proposed rates; supplementary rate information such as underwriting and rating adjustment factors; supporting information such as actuarial certifications and loss ratios; policy forms and endorsements. Testing included a review of rates and rating factors used by the Company during the examination period compared with those filed and deemed approved for use during the same period, with no exceptions noted.

The examiner tested the accuracy of premiums charged in the individual and group market by performing recalculations of selected sample files. The selected sample files were also reviewed to verify the proper application of underwriting and rating factors were used. The rates and factors were calculated and verified without exception.

Recommendations:
None

Standard J 2 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § J, Standard 2*
Review Methodology: Sample
Disclosures to insured concerning rates and coverage are accurate and timely.
Tenn. Code Ann. §§ 56-7-2208, 56-7-2209, and 56-8-104(1)

Comments:
It is necessary to provide insureds with appropriate disclosures, both mandated and reasonable. Without appropriate disclosures, insureds find it difficult to make informed decisions. Disclosures the examination was concerned with were as follows:

- Ten (10) day free look period;
- Pre-existing provisions;
- Renewal, continuing and non-renewal coverage provisions;
- Replacement Notices if existing coverage is being replaced; and
- Definitions of reasonable and customary (UCR).

Results:
Pass

Observations:
The review of group and individual policy forms including an assessment to verify disclosure requirements noted above satisfied the requirements outlined.

Recommendations:
None

Standard J 3 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § J, Standard 3*
Review Methodology: Generic and Sample
The Company does not permit illegal rebating, commission cutting or inducements.
Tenn. Code Ann. § 56-8-104(7)

Comments:
Testing is generally file specific. Illegal rebating, commission cutting or other illegal inducements are forms of unfair discrimination.

Results:
Pass

Observations:
A review of the one hundred (100) underwriting files did not evidence any rebating, commission cutting or other inducements.

Table J 3 Underwriting

Type	Sampled	N/A	Pass	Fail	% Pass
Individual Files	34	0	34	0	100%
Small Group Files	33	0	33	0	100%
Large Group Files	33	0	33	0	100%
TOTAL	120	0	100	0	100%

Recommendations:
None

Standard J 4 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § J, Standard 4*

Review Methodology: Generic and Sample
All forms, including contracts, riders, endorsement forms and certificates, are filed with the department of insurance, if applicable.

Tenn. Code Ann. §§ 56-2-105, 56-26-102(a), 56-29-104, 56-29-107, 56-29-116, 56-29-117 and Tenn. Comp R. & Regs. 0780-1-20.

Comments:
A Company contract issued with forms that have not been filed and approved are technically not a part of the contract.

The concerns tested with the standard include:

- Determining if the forms and endorsements have been filed
- Where required, determining either prior approval has been obtained or the applicable waiting periods following the filing have been met

Results:
Pass

Observations:
All forms and endorsement used in the underwriting files were on file with the TDCI. No exceptions were noted.

Table J 4 Underwriting

Type	Sampled	N/A	Pass	Fail	% Pass
Individual Files	34	0	34	0	100%
Small Group Files	33	0	33	0	100%
Large Group Files	33	0	33	0	100%
TOTAL	120	0	100	0	100%

Recommendations:
None

Standard J 5 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § J, Standard 5.*
Review Methodology: Generic and Sample
The Company underwriting practices are not to be unfairly discriminatory. The Company adheres to applicable statutes, rules and regulations, and company guidelines in selection of risks.

Tenn. Code Ann. §§ 56-8-104(6), 56-8-104(14)

***Comments*:**
It is necessary to provide insureds with appropriate protections from unfair discrimination. Inconsistent handling of rating or underwriting practices, including requests for supplemental information, even if not intentional, can result in unfair discrimination. Concerns tested with this standard include:

- Underwriting decisions supported by data in the underwriting file.
- Consistent application of underwriting criteria.
- Company is following its underwriting guidelines.
- Underwriting guidelines are consistent with Tennessee statutes.

Results:
Pass

Observations:
The Company's underwriting guidelines and samples of thirty-four (34) individual, thirty-three (33) small group and thirty-three (33) large group underwriting files were reviewed to determine whether the Company refused to insure, continue to insure, or limited the coverage for any unfair discriminatory reason. The Company has no, nor employed any, unfairly discriminatory practices in this review. No exceptions were noted.

Recommendations:
None

Standard J 6 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § J, Standard 6*
Review Methodology: Sample
Producers are properly licensed and appointed (if required) for the jurisdiction where the application was taken.

Tenn Code Ann. §§ 56-6-103, 56-6-107, 56-6-111, 56-6-113, 56-6-115, 56-6-117, 56-6-118, and 56-6-125

Comments:
This standard has a direct insurance statutory requirement. This standard is aimed at assuring compliance with the requirement that producers be properly licensed and appointed for business solicited in Tennessee.

Results:
Pass

Observations:

The producer was identified in fifty (50) underwriting files. Producer appointment and license was tested to determine if they were in effect prior to negotiation and sale of the policy. The Company did not present sufficient evidence that the producer was licensed at the time of the policy issue date for two (2) sampled policies. Tenn. Code Ann. § 56-6-103 requires a license in order for producers to transact business on behalf of the Company.

Table J 6 Underwriting

Type	Sampled	N/A	Pass	Fail	% Pass
Underwriting/Producer License	50	0	48	2	96%

Recommendations:
None

Standard J 7 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § J, Standard 7*
Review Methodology: Sample
File documentation adequately supports decisions made.

Comments:
This standard does not have a direct insurance statutory requirement. Proper documentation of files reduces the likelihood of unfair discrimination.

Results:
Pass

Observations:
The examiner reviewed individual and group underwriting files and determined the files contained necessary information to support classification, rating and selection decisions made. Documentation with respect to rate development and eligibility was adequate.

Table J 7 Underwriting

Type	Sampled	N/A	Pass	Fail	% Pass
Individual Files	34	0	34	0	100%
Small Group Files	33	0	33	0	100%
Large Group Files	33	0	33	0	100%
TOTAL	120	0	100	0	100%

Recommendations:
None

Standard J 8 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § J, Standard 8*
Review Methodology: Generic and Sample
Policies, riders and endorsements are issued or renewed accurately, timely and completely.
Tenn. Code Ann. § 56-26-118

Comments:
Policies, riders and endorsements should be issued timely and consistent with the information contained in the underwriting file and no change shall be made except with the applicants written permission.

Results:
Pass with recommendation

Observations:
Time studies were performed on sample individual and group underwriting files and determined policies were issued in appropriate time frames. No exceptions were noted.

The examiners reviewed the sample underwriting files to determine if applications contain any alterations made by persons other than the applicants without written consent of the applicants. The examiner requested the Company provide documentation of any Company policies related to the alteration of insurance applications.

The examiner noted twenty-three (23) applications for coverage, (five (5) individual, fifteen (15) small group and three (3) large group)) that contained alterations made by Company sales personnel. The files contained no evidence of written authorization from the applicant as required by Tenn. Code Ann. § 56-26-118. Applicable statutes allow for insertions made by the insurer for administrative purposes only, in such a manner as to indicate clearly that the insertions are not to be ascribed to the applicant. The alterations noted were initialed and dated by the sales personnel responsible for the file and were all apparent corrections or additions to data entered by the applicant that ultimately was determined to be entered wrong. None of the additions or corrections observed had any effect on the underwriting, acceptance or rating of the risks and could be interpreted to have been made to avoid administrative delays in processing of applications.

Table J 8 Underwriting

Type	Sampled	N/A	Pass	Fail	% Pass
Individual Applications	34	0	34	0	100%
Small Group Applications	33	0	33	0	100%
Large Group Applications	33	0	33	0	100%
TOTAL	120	0	120	0	100%

Recommendations:
It is recommended the Company adopt and implement written guidelines and procedures to establish that producers and Company personnel may make additions or changes to applications for administrative purposes only and properly define what additions or changes that would be considered administrative in nature so as to ensure compliance with the provisions of Tenn. Code Ann. § 56-26-118.

Standard J 9 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § J, Standard 9*
Review Methodology: Sample
Rejections and declinations are not unfairly discriminatory.
Tenn. Code Ann. § 56-8-104(6)

***Comments*:**
The Company should use reasons for rejection/declination that are not discriminatory and the Company should provide such reasons to the policyholder where required. Concerns tested with this standard include:

- The company is following its Internal Underwriting guidelines.
- Underwriting practices are not unfairly discriminatory

Results:
Pass

Observations:
A sample of rejected or declined applications was reviewed. The Company properly provided written denials that included the reasons for denial which were not unfairly discriminatory. No exceptions were noted.

Recommendations:
None

Standard J 10	*NAIC Market Conduct Examiners Handbook – Chapter XVII, § J, Standard 10*
Review Methodology: **Cancellation/non-renewal/discontinuance notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract.**	*Tenn. Code Ann. §§ 56-7-2803, 56-26-109 and 56-7-2810*

***Comments*:**
An enrollee shall be given thirty (30) days notice of any cancellation or non-renewal and the notice shall include the reasons for the cancellation or non-renewal. Additionally, health insurers shall furnish Certificates of Creditable Coverage, without charge, for individuals covered under a health benefit plan when either the group or individual terminate from the plan.

Results:
Pass

Observations:
Policies issued by the Company are guaranteed renewable and policy provisions as well as Tennessee statutes allow for termination by the Company for a limited number of reasons. All of the reasons noted for the termination of the sample files comply with termination provisions permitted per Tenn. Code Ann. § 56-7-2810(b). Certificates of creditable coverage were issued when appropriate. No exceptions were noted.

Recommendations:
None

Standard J 11	*NAIC Market Conduct Examiners Handbook – Chapter XVII, § J, Standard 11*
Review Methodology: Generic and Sample **Cancellation practices comply with policy provisions, HIPAA and state laws.**	*Tenn. Code Ann. § 56-7-2810*

***Comments*:**
Companies may not cancel or fail to renew the coverage of an enrollee except for: (a) Failure to pay the charge for health care coverage; (b) termination of the group plan; (c) enrollee moving out of the area served; (d) enrollee moving out of an eligible group for policies purchases pursuant to the Tennessee Health Insurance Portability, Availability and Renewability Act. .

Results:
Pass with recommendation

Observations:
In a review of policy forms, the examiner noted the Company includes in its policy forms a provision for termination of coverage that is not permitted by Tenn. Code Ann. § 56-7-2810(b). In addition to the provisions for termination allowed by the statute, the

Company includes the following provision in the policy forms allowing the Company to terminate coverage if:

> 3. "You act in such a disruptive manner as to prevent or adversely affect the ability of BCBST to administer the Policy."

Recommendations:
It is recommended the Company not include in policy forms the termination provisions not permitted pursuant to Tenn. Code Ann. § 56-7-2810(b).

Standard J 12	*NAIC Market Conduct Examiners Handbook – Chapter XVII, § J, Standard 12*
Review Methodology: Sample	
Unearned premiums are correctly calculated and returned to appropriate party in a timely manner and in accordance with applicable statutes, rules and regulations.	
	Tenn Code Ann. § 56-26-109

Comments:
Companies are required to return unearned premium in a timely manner.

Results:
Pass

Observations:
The sample cancellations were tested to determine if unearned premium was correctly calculated. Most cancellations were for non-payment of premium. The Company did correctly calculate unearned premium in all cases where unearned premium was received. Unearned premium was returned timely.

Recommendations:
None

Standard J 13	*NAIC Market Conduct Examiners Handbook – Chapter XVII, § J, Standard 13*
Review Methodology: Sample	
Rescission is not made for non-material misrepresentation.	
	Tenn. Code Ann. §§ 56-7-103 and 56-26-119

Comments:
This standard is intended to ensure rescission of coverage is not for unfairly discriminatory reasons.

Results:
Pass

Observations:
Twenty (20) rescinded policy files were reviewed to determine if decisions to rescind policies were made in accordance with applicable statutes, rules and regulations. The

reasons for rescission were for material misrepresentation and deemed appropriate. No exceptions were noted.

Table J 13 Underwriting

Type	Sampled	N/A	Pass	Fail	% Pass
Rescinded Applications	20	0	20	0	100%

Recommendations: **None**

Standard J 14 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § J, Standard 14*
Review Methodology: Sample
Pertinent information on application that forms a part of the policy are complete and accurate.

Tenn. Code Ann. §§ 56-7-102 and 56-2-118

Comments:
Applications should be signed and any changes to the application and supplements to the application should be initialed by the applicant.

Results:
Pass

Observations:
In the documentation testing of individual and group underwriting, the examiner reviewed files to determine if coverages were issued as applied for and if applications were complete. All applications contained in the individual new business, small group new business and large group new business sample were reviewed to determine they were signed and any alterations were initialed. Alterations were made to applications and exceptions were noted in Standard J 8. The alterations did not affect coverage being issued as applied for. Applications were complete and signed.

Recommendations:
None

Standard J 15 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § J, Standard 15*
Review Methodology: Generic
Company complies with the provisions of COBRA and/or continuation of benefits procedures contained in policy forms, statutes, rules and regulations.

Tenn. Code Ann. § § 56-7-2312 and 56-7-2810

Comments:
The Company should have procedures for providing information pertaining to continuation of benefits, for processing applications for continuation of benefits and for notification to insureds.

Results:
Pass

Observations:

The Company includes specific disclosure of the availability of COBRA continuation coverage offered to members of group plans. The Company also provides detailed procedures and requirements to members and employers for enrollment in COBRA coverage upon federally defined qualifying events if the Company has contracted with the employer to administer COBRA services.

The Company provides COBRA administration services which are offered only to groups of twenty (20) or more members. The Company makes the COBRA administration services available as an option and rider to the group agreement for a nominal fee. The core group agreement itself places the responsibility of determination of and notification to eligible members on the employer. The Company was in compliance with the provisions of COBRA.

Recommendations:
None

Standard J 16 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § J, Standard 16*
Review Methodology: Generic
The Company complies with proper use and protection of health information in accordance with statutes, rules, and regulations.
Tenn. Code Ann. § § 56-7-124, amd 56-8-119

Comments:
This standard is intended to assure the Company provides adequate protection of information it holds concerning its policyholders and minimizes any improper intrusion into the privacy of applicants and policyholders.

Results:
Pass

Observations:
The Company has procedures in place for the proper use of protected health information including underwriting guidelines for AIDS and the use of medical/lifestyle questions. The applications and health questionnaires used in underwriting individual and group coverage contain no improper questions.

Recommendations:
None

Standard J 17 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § J, Standard 17*
Review Methodology: Generic and Sample
Standard: Statutory
The Company complies with the provisions of HIPAA and state laws regarding limits on the use of pre-existing exclusions.
Tenn. Code Ann. § 56-7-2809

Comments:
A health insuring entity may impose a preexisting condition exclusion with respect to an individual covered under a health benefit plan only if medical advice, diagnosis, care or

treatment for the condition was recommended or received within the six (6) month period preceding the individual's enrollment date. Medical advice, diagnosis, care or treatment is taken into account only if it is recommended by, or received from, a medical care provider. Genetic information is not a preexisting condition unless a condition related to the information has been diagnosed. Pregnancy may not be excluded from coverage as a preexisting condition. Unless a child has had a significant break in coverage, no preexisting condition exclusion may be imposed with regard to a child who:

- Is covered under any creditable coverage as of the last day of the thirty (30) day period beginning with the date of birth; or
- Is adopted or placed for adoption before attaining the age of eighteen (18) years and who, as of the last day of the thirty (30) day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage.

A preexisting condition exclusion may not extend for more than a twelve (12) month period (eighteen (18) month period for a late enrollee) beginning on an individual's enrollment date. Any preexisting condition exclusion otherwise applicable to an individual shall be reduced by the number of days of creditable coverage the individual has as of the enrollment date.

Results:
Pass

Observations:
The review of group underwriting guidelines and evidence of coverage forms indicated the Company properly complies with the required provisions of HIPAA and Tennessee statutes with regard to the imposition of preexisting condition exclusions and/or limitations and with applicable provisions regarding consideration and application of creditable coverage.

Recommendations:
None

Standard J 18 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § J, Standard 18*
Review Methodology: Generic and Sample
The Company does not improperly deny coverage or discriminate based on health status in the group market or against eligible individuals in the individual market in conflict with the requirements of HIPAA.

Tenn. Code Ann. §§ 56-7-2803, 56-7-2809 and 56-7-2810

Comments:
No individual eligibility determination may be made using health status, physical or mental medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability. A special enrollment period must be allowed for changes in family status including a spouse that declined coverage at open enrollment due to "other coverage" and subsequently lost coverage. Similarly

situated individuals cannot be charged a higher premium, pay higher contribution amounts, or have limitations or restrictions on their benefits or coverage.

Results:
Pass

Observations:
A review of the underwriting files indicated the Company did not deny coverage or rate up individuals within a group for a mental medical condition, claim experience, receipt of health care, medical history, genetic information, or disability. No individual or group members were denied eligibility for coverage or charged different premiums in conflict with the requirements of HIPAA.

Recommendations:
None

Standard J 19	*NAIC Market Conduct Examiners Handbook – Chapter XVII, § J, Standard 19*
Review Methodology: Generic and Sample	
The Company issues coverage that complies with guaranteed issue requirements of HIPAA and related state laws for groups of two (2) to fifty (50).	*Tenn. Code Ann. §§ 56-7-2803, et seq.*

Comments:
Small group coverage must be issued on a guaranteed issue basis for all products, subject to participation and contribution requirements. No eligible employee or dependent may be excluded on the basis of health status or related factors.

Results:
Pass

Observations:
The Company did not deny coverage to any groups with two (2) to fifty (50) eligible employees. No evidence was noted that indicated any individual group members were denied eligibility for group coverage or charged different premiums based on personal health status, claims experience or genetic information,

Recommendations:
None

Standard J 20	*NAIC Market Conduct Examiners Handbook – Chapter XVII, § J, Standard 20*
Review Methodology:	
The Company issues individual insurance coverage to eligible individuals entitled to portability under the provisions of HIPAA and in compliance with statutes, rules, and regulations.	*Tenn. Code Ann. §§ 56-7-2809 and 56-7-2811 and 56-7-2810*

Comments:

On and after July 1, 1997, each health insurance issuer that offers individual health insurance coverage in Tennessee must offer to and accept for enrollment every eligible individual who applies for coverage without imposing any preexisting condition exclusion with respect to such coverage.

Results:
Pass

Observations:
The Company offers coverage to eligible individuals entitled to portability under the provisions of HIPAA. The Company complies with the provisions of Tenn Code Ann. § 56-7-2809 in offering two (2) policy forms that provide higher level and lower level coverages as described and permitted in the statute.

Recommendations:
None

K. UTILIZATION REVIEW

Comments:
Evaluations of the standards in this business area are based on Company responses to various information requests and review of Company policies and procedures. The utilization review portion of the examination is designed to assure that the company and their designees that provide or perform utilization review services comply with standards and criteria for the structure and operation of utilization review processes. The NAIC defines utilization review as a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, external review or retrospective review.

The areas to be considered in this kind of review include the Company's written utilization review policies and procedures, annual summary reports, timeliness in making utilization review decisions and handling appeals, communications with members about the program, and oversight of delegated utilization review functions.

Standard K 1 *NAIC Market Conduct Examiners Handbook – Chapter VIII, §K, Standard 1*
Review Methodology: Generic
The health carrier establishes and maintains a utilization review program in compliance with statutes, rules, and regulations.

Comments:
The standard does not have a direct statutory requirement. This standard is aimed at verifying that the Company has a valid utilization review program in place.

Results:

Pass

Observations:
The Company's utilization review program known as the "Utilization Management Program," provides oversight for inpatient services (hospital, rehabilitation and nursing facilities), select outpatient services (including observation), transition of care, and ancillary services (home health care). The utilization review program is directed and guided by the corporate medical director who is a medical doctor.

Utilization Management Program issues polices and procedures, and reports are initially presented to the utilization management sub-committee. The subcommittee's actions or recommendations are presented to the Medical Management Committee for final approval. The Board of Directors has delegated oversight of the quality improvement program (including utilization management) and associated quality improvement activities to the delivery system committee.

The Company has a written and up to date utilization review program in place.

Recommendations:
None

Standard K-2	*NAIC Market Conduct Examiners Handbook – Chapter VIII, §K, Standard 2*
Review Methodology: Generic	
The Company files with the Commissioner an annual summary report of its utilization review activities.	

Comments:
The standard does not have a direct statutory requirement. This standard is concerned with whether the Company makes their utilization review program available for review to the TDCI.

Results:
Not Applicable – See explanation under observations.

Observations:
The Company is not required to file a report with the Commissioner of TDCI on its utilization review activities.

Recommendations:
None

Standard K-3	*NAIC Market Conduct Examiners Handbook – Chapter VIII, § K, Standard 3*
Review Methodology: Generic	
The Company provides information about its utilization review program to members in a timely manner and in compliance with statutes, rules, and regulations.	

Comments:

The standard does not have a direct statutory requirement. This standard is concerned with whether the Company effectively communicates the utilization review process to members.

Results:
Pass

Observations:
The Company addresses prior authorization and concurrent review in its member booklet. The Company also addresses prior authorization in the medical management section of the explanation of coverage form.

Recommendations:
None

Standard K 4 *NAIC Market Conduct Examiners Handbook – Chapter VIII, §K, Standard 4*
Review Methodology: Generic and Sample
The Company conducts provider related utilization review activities in a timely manner and in compliance with statutes, rules, and regulations.

Comments:
The standard does not have a direct statutory requirement. This standard is concerned with whether the Company has procedures in place for the timely handling of utilization review activities.

Results:
Pass

Observations:
The provider agreement requires the provider to participate in and abide by the Company's Utilization Review Program. The Company gives all providers one (1) toll free phone number for utilization review inquiries. The Company has adequate procedures that provide access to records. The Company has procedures in place to ensure utilization review activities proceed timely.

Recommendations:
None

Standard K 5 *NAIC Market Conduct Examiners Handbook – Chapter VIII, § K, Standard 5*
Review Methodology: Generic and Sample
The Company makes utilization review decisions in a timely manner and as required by state statutes, rules, and regulations and the provisions of HIPAA.

Comments:
The standard does not have a direct statutory requirement. This standard is concerned that the Company handles utilization review requests in a timely manner. Untimely handling of utilization can review may have an adverse effect on the health of members.

Results: **Pass**

Observations:
A sample of fifty (50) utilization review files was reviewed to determine whether the Company notified the provider and the subscriber of its determination in a timely manner. The Company made the determination within two (2) days in forty-three (43) of the files reviewed. Of the seven reviews not processed within two (2) days, four (4) of those were preauthorization requests and the remaining three (3) were appeals of previous utilization review decisions. The Company processed utilization reviews in a timely manner. No exceptions were noted.

Recommendations:
None

Standard K 6 *NAIC Market Conduct Examiners Handbook – Chapter VIII, §K, Standard 6*
Review Methodology: Generic and Sample
The Company provides written notice in compliance with statutes, rules, and regulations for an adverse determination.

Comments:
The standard does not have a direct statutory requirement. This standard is concerned that the Company provides written notice to affected parties so that members may make informed subsequent decisions regarding health care.

Results:
Pass

Observations:
The sample of fifty (50) utilization review files was reviewed to determine whether the Company provided the clinical rationale in writing for adverse determinations, including the clinical review criteria used to make the determination. The Company provided written notification to the provider, the facility and the member. The Company did not include the clinical rationale in the determination letters sent. However, the determination letters from the Company did state clinical review criteria used for the determination would be provided in writing upon receipt of a written request.

Recommendations:
None

Standard K 7 *NAIC Market Conduct Examiners Handbook – Chapter VIII, § K, Standard 7*
Review Methodology: Generic
The Company makes reconsideration decisions in a timely manner and in compliance with state statutes, rules, and regulations.

Comments:

The standard does not have a direct statutory requirement. This standard is concerned that the Company has procedures in place for timely reconsiderations.

Results:
Pass

Observations:
The sample of fifty (50) utilization review files was reviewed to determine whether the Company afforded providers the opportunity to request a reconsideration of adverse determinations. Initial determination letters indicate the Company will honor all requests for reconsideration received within sixty (60) days of the adverse determination.

Recommendations:
None

Standard K 8	*NAIC Market Conduct Examiners Handbook – Chapter VIII, § K, Standard 8*
Review Methodology: Generic	
The Company conducts standard appeals in compliance with applicable statutes, rules, and regulations.	

Comments:
The standard does not have a direct statutory requirement.

Results:
Pass

Observations:
Guidelines for standard appeals require review by a health reviewer who is a clinical peer, holds an active license, is Board Certified in the same specialty, is in the same or similar profession and is neither the individual who made the original non-certification, nor the subordinate of such an individual. Three (3) standard appeals reviewed in the sample were handled within thirty (30) days. Standard appeals were handled in accordance with NAIC guidelines.

Recommendations:
None

Standard K 9	*NAIC Market Conduct Examiners Handbook – Chapter VIII, § K, Standard 9*
Review Methodology: Generic	
The Company conducts expedited appeals in a timely manner and in compliance with applicable statutes, rules, and regulations.	

Comments:
The standard does not have a direct statutory requirement. This standard is concerned that the Company offers expedited appeals to members where the condition of the member may be in jeopardy.

Results:
Pass

Observations:
The Company has guidelines for expedited appeals within their Utilization Management Program. An expedited review may be requested when the provider believes that the adverse determination might seriously jeopardize the life or health of a member. In addition, the Company imposes timeliness requirements for processing expedited reviews.

Recommendations: **None**

Standard K 10	*NAIC Market Conduct Examiners Handbook – Chapter VIII, § K, Standard 10*
Review Methodology: Generic	
The Company conducts utilization review activities and provides for emergency services in compliance with statutes, rules, and regulations.	

Comments:
The standard does not have a direct statutory requirement. This standard is concerned that the members have access to emergency services.

Results:
Pass

Observations:
According to the information provided to its members, the Company provides twenty-four (24) hours, seven (7) days a week access to authorized representatives. The member booklet indicates no prior authorization is required for emergency services.

Recommendations:
None

Standard K 11	*NAIC Market Conduct Examiners Handbook – Chapter VIII, § K, Standard 11*
Review Methodology: Generic	
The Company monitors the activities of the utilization review organization or entity with which the carrier contracts.	

Comments:
The standard does not have a direct statutory requirement. This standard is concerned that the Company has proper oversight of third parties performing business functions.

Results:
Not Applicable – See explanation under observations.

Observations:
The Company does not contract with third parties for utilization review services.

Recommendations:
None

L. CLAIMS PRACTICES

Comments:
The evaluation of standards in this business area was based on the Company's responses to information requested by the examiner, discussions with the Company's staff; electronic testing of claim databases and file sampling during the examination process. This portion of the examination is designed to provide a view of how the Company treats claimants and whether that treatment complies with applicable statutes, rules and regulations.

Claims to the Company usually arise from a provider who delivers services to a member of the Company. These providers are usually under contract to the Company to provide certain services reimbursed at contracted levels.

The Company receives and processes over seventy percent (70%) of claims electronically without processor intervention. Claims with potential coordination of benefits, cosmetic or investigational procedures, pre-existing conditions and duplicates are handled manually by the Company. All claims, including those not received electronically, are maintained electronically and therefore, no hard copy claim files were provided or reviewed.

Claim testing was done to determine if the Company's treatment of claimants is in compliance with Tenn. Code Ann. § 56-8-104(8). The Company provided complete listings of Tennessee claims, including paid, closed without payment and pending claims for individual, small group and large group market. From these listings, samples of one hundred (100) claims were selected from each area, except for pending individual claims, where fifty (50) sample items were selected. The samples were selected using ACL software, based on a ninety-five percent (95%) confidence level.

Following is a listing of the populations and sample sizes reviewed:

Area of Review	Population	Sample Size
Individual – Paid	2,718,856	100
Individual – Closed without Payment	846,166	100
Individual – Pending	4,109	50
Small Group – Paid	5,618,598	100
Small Group – Closed without Payment	983,556	100
Small Group – Pending	15,470	100
Large Group – Paid	2,124,899	100
Large Group – Closed without Payment	621,510	100

Large Group – Pending	10,099	100

Standard L 1 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § L, Standard 1.*
Review Methodology: Generic and Sample
Standard: Statutory
The initial contact by the company with the claimant is within the required time frame.

Tenn. Code Ann. § 56-8-104(8)(A)(ii) and (iii) and 56-7-109

Comments:
Tenn. Code Ann. § 56-8-104 requires the Company to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.

Results:
Pass

Observations:
Samples of one hundred (100) paid claims each in the individual, small group and large group market were selected randomly for testing this standard. The Company does not have procedures for the acknowledgement of claims and therefore the initial contact or acknowledgement occurs when the claim is settled. For those claims that require additional communications or further investigation, the acknowledgement date is the day the Company initially contacts the member or the provider. The Company settled all claims tested in accordance with Tenn. Code Ann. § 56-7-109 ((settlement within twenty-one (21) days for electronic claims and thirty (30) days for paper claims)) and was deemed to be in compliance with this standard.

Table L 1 Claims

Paid Claims	Sampled	N/A	Pass	Fail	% Pass
Individual Paid Claims	100	0	100	0	100%
Small Group Paid Claims	100	0	100	0	100%
Large Group Paid Claims	100	0	100	0	100%
TOTAL	300	0	300	0	100%

Recommendations:
None

Standard L 2 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § L, Standard 2.*
Review Methodology: Generic, Sample and Electronic
Standard: Statutory
Investigations are conducted in a timely manner.

Tenn. Code Ann. § 56-8-104(8)(A)(viii)

Comments:
In a Company setting, failure to investigate claims timely can result in a migration of providers from the network, with resultant disruption of service to members.

Results:
Pass

Observations:
When a preliminary report is received from the Provider, the company does not require the subsequent submission of formal proof of loss unless in the Company's judgment, a sworn proof of loss is necessary to establish a liability or amount due to the claimant. Claim testing determined the Company settled all claims tested in accordance with Tennessee law and was deemed to be in compliance with this standard.

Standard L 3 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § L, Standard 3.*
Review Methodology: Generic, Sample and Electronic
Standard: Statutory
Claims are resolved in a timely manner

Tenn. Code Ann. §§ 56-7-109, 56-8-104(8)(A)(ix) and (x), 56-7-105

Comments:
In a Company setting, failure to resolve claims timely can result in a migration of providers from the network, with resultant disruption of service to members. Tenn. Code Ann. § 56-7-109 requires claim resolution within twenty-one (21) calendar days of receipt of claim if submitted electronically and thirty (30) calendar days if submitted on paper. If the Commissioner of TDCI finds a health insurance entity has failed during any calendar year to properly process and pay ninety-five percent (95%) of all clean claims received from all providers during that year, the Commissioner of TDCI may levy a penalty.

Results:
Pass

Observations:
The examiners electronically reviewed the entire population of claims the Company's adjudicated between January 1, 2003 and September 30, 2004 for adherence to the aforementioned criteria. The Company paid in excess of ninety-eight percent (98%) of claims received within prompt pay guidelines and was deemed to be in compliance with Tenn. Code Ann. § 56-7-109. (Claims received and processed for Out-of-State BlueCross members were excluded from the population as they were not subject to prompt pay guidelines.)

Table L 3 (a) Prompt Pay

Paid Claims	Population	Failures	% Pass
Individual Paid Claims	1,858,968	7,054	99.6
Small Group Paid Claims	1,733,226	68,135	98.7
Large Group Paid Claims	5,168,319	21,606	98.8

The examiners reviewed a sample of one hundred (100) paid claims from each of the business groups to verify accuracy of the electronic data and to verify compliance with resolution times required by Tenn. Code Ann. § 56-7-109 and no exceptions were noted.

Table L 3 (b) Claims

Paid Claims	Sampled	N/A	Pass	Fail	% Pass
Individual Paid Claims	100	0	100	0	100%
Small Group Paid Claims	100	0	100	0	100%
Large Group Paid Claims	100	0	100	0	100%
TOTAL	300	0	300	0	100%

Additionally, a sample of one hundred (100) emergency room claims were tested from each of the groups to determine if claims were paid timely and in accordance with policy provisions and Tennessee statutes. Six (6) claims in the individual paid sample were not settled within prompt pay guidelines. The Company paid three (3) of these claims to the wrong provider and was deemed to be in compliance with Tenn. Code Ann. § 56-7-109.

Table L 3 (c) Claims

Closed Without Payment ER Claims	Sampled	N/A	Pass	Fail	% Pass
Individual ER Claims	100	0	100	6	94%
Small Group ER Claims	100	0	100	0	100%
Large Group ER Claims	100	0	100	0	100%
TOTAL	300	0	300	0	100%

Recommendations:
None

Standard L 4 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § L, Standard 4*
Review Methodology: Generic and Sample
Standard: Statutory
The Company responds to claim correspondence in a timely manner.
Tenn. Code Ann. § 56-8-104(8)(A) (ii) and (iii)

Comments:
None

Results:
Pass

Observations:
The Company written standard is to respond to ninety percent (90%) of the claims correspondence within seven (7) days. Samples of one hundred (100) paid claims each in the individual, small group and large group market were selected randomly for testing this standard. The results of the testing show that claims correspondence was acknowledged and acted upon promptly by the Company as required by Tenn. Code Ann. § 56-8-104(8)(A)(ii) and (iii).

Recommendations:

None

Standard L 5 *NAIC Market Conduct Examiners Handbook - Chapter XVII, § L, Standard 5.*
Review Methodology: Generic and Sample
Standard: Statutory
Claim files are adequately documented.

Tenn. Code Ann. § 56-1-411(b)(1)

Comments:
Without adequate documentation, the various time frames required by statute and/or regulation cannot be demonstrated. TDCI requires that an insurer's claim files contain all notes and work papers pertaining to the claim in such detail that such pertinent events and the dates of such events can be reconstructed.

Results:
Pass

Observations:
Samples of one hundred (100) paid claims each in the individual, small group and large group market were selected randomly for testing this standard. All claim files are maintained electronically on the Company's computer claim handling system. Claim files included claim forms, scanned documents, adjuster's notes and an Explanation of Benefits ("EOB"). Claim files were reviewed to determine if documentation sufficiently supported or justified the ultimate claim determination. Claim files contained adequate documentation. No exceptions were noted.

Table L 5 Claims

Paid Claims	Sampled	N/A	Pass	Fail	%Pass
Individual Paid Claims	100	0	100	0	100%
Small Group Paid Claims	100	0	100	0	100%
Large Group Paid Claims	100	0	100	0	100%
TOTAL	300	0	300	0	100%

Recommendations:
None

Standard L 6 *NAIC Market Conduct Examiners Handbook - Chapter XVII, § L, Standard 6.*
Review Methodology: Generic and Sample
Standard: Statutory
Claims are properly handled in accordance with policy provisions and applicable statutes, rules and regulations.

Tenn. Code Ann. § § 56-7-124 and 56-8-119

Comments:
Claim files should be handled in accordance with policy provisions and the requirements of the HIPAA. Under HIPAA, the federal legislation allows people to carry earned

coverage time from one (1) group to another without or limited impact of non-coverage of benefits related to the pre-existing waiting period.

Results:
Pass

Observations:
The examiners reviewed Company procedures and policy provisions and a sample of three hundred (300) paid claims to determine compliance with policy provisions, Tennessee statutes and the requirements of HIPAA including pre-existing exclusions. No exceptions were noted.

Recommendations:
None

Standard L 7	*NAIC Market Conduct Examiners Handbook – Chapter XVII, § L, Standard 7.*
Review Methodology: Generic	
Company claim forms are appropriate for the type of product.	
	Tenn Code Ann. § § 56-7-1008, 56-1-104, and Tenn. Comp. R. & Regs. 0780-1-20-.09

Comments:
Tenn. Code Ann. § 56-7-1008 gives the commissioner the discretion to provide claim forms for reporting by health care providers.

Results:
Pass

Observations:
The claim forms used by the Company are the Health Insurance Claim Form CMS1500 and the Hospital Inpatient Claim Form UB-92. The forms were developed by the Centers for Medicare and Medicaid Services and are intended to be a uniform claim form for use by all health care providers. The review of the claim forms used by the Company determined the forms included the appropriate content including a fraud warning statement. The review further determined the claim forms were used appropriately. No exceptions were noted.

Recommendations:
None

Standard L 8	*NAIC Market Conduct Examiners Handbook – Chapter XVII, § L, Standard 8.*
Review Methodology: Generic	
Claim files are reserved in accordance with the Company's established procedures.	
	Tenn. Code Ann. § 56-2-301; Tenn. R. & Regs. 0780-1-69

Comments:

The Tennessee Rules set forth standards to determine that insurance companies maintain an adequate amount of reserves to cover claims.

Results:
Pass

Observations:
Company procedures were reviewed to determine if reserve adjustments are made, and if reserves are adequate. The Company does not maintain reserves by policy but rather reserves are done on an aggregate basis by product and separated by the type of service. The claims reserving process begins with the estimation of claims activity. Reserve adjustments are based on these estimates, and are performed monthly. Claim reserving practices appear to be adequate. No exceptions were noted.

Recommendations:
None

Standard L 9 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § L, Standard 9.*
Review Methodology: Generic and Sample
Denied and closed-without-payment claims are handled in accordance with policy provisions, HIPAA and Tennessee law.
Tenn. Code Ann. § 56-8-104(8)(A)(ii) and (iii) and Federal HIPAA

Comments:
This standard does not have a direct insurance statutory requirement. Claim files should be handled in accordance with policy provisions and the requirements of the HIPAA. The Company should have procedures in place, which assure that no exclusions of coverage are imposed for a pre-existing condition where HIPAA pre-existing condition exclusion maximums have been reached, or claims denied where an individual has periods of creditable coverage that should be credited from prior coverage. The claims were reviewed for the following:

- Claims are not inappropriately denied;
- Deductibles and Co-payments and Coinsurance were properly applied; and
- EOB correctly explained member responsibility.

Results:
Pass

Observations:
*S*amples of one hundred (100) closed-without-payment claims from the individual, small group and large group market were selected randomly for testing this standard. The samples were reviewed to determine whether the Company's handling of these claims was justified and was not unfairly discriminatory. The reasons for the denials were included in the EOB. The EOB contained a statement informing claimants of their right

to appeal the Company's decision. Denials were determined to be justified and in compliance with policy provisions, statute and HIPAA.

Table L 9 (a) Claims

Closed Without Payment Claims	Sampled	N/A	Pass	Fail	% Pass
Individual Claims	100	0	100	0	100%
Small Group Claims	100	0	100	0	100%
Large Group Claims	100	0	100	0	100%
TOTAL	300	0	300	0	100%

Additionally, a sample of one hundred (100) emergency room claims were tested from each of the groups to determine if claims were denied timely and in accordance with policy provisions and State law. Claims were reviewed to determine if they were paid within prompt pay guidelines and subsequently denied. No exceptions were noted in this review.

Table L 9 (b) Claims

Closed Without Payment ER Claims	Sampled	N/A	Pass	Fail	% Pass
Individual ER Claims	100	0	100	0	100%
Small Group ER Claims	100	0	100	0	100%
Large Group ER Claims	100	0	100	0	100%
TOTAL	300	0	300	0	100%

Recommendations:
None

Standard L 10 *NAIC Market Conduct Examiners Handbook – Chapter XVII, § L, Standard 10.*
Review Methodology: Sample
Canceled benefit checks and drafts reflect appropriate claim handling practices.

Comments:
Concerns tested with this standard include:

- Payments are to the correct payee and in the correct amount
- Whether checks purport to release the Company from further liability

Results:
Pass

Observations:
Samples of ten (10) paid claims each in the individual, small group and large group market were selected randomly for testing this standard. The Company does not use drafts in payment of its claims. Payment of claims is made via check or electronically. The Company also does not use releases. Claim payments are made primarily to the provider on a billing basis rather than to a member on a reimbursement basis, therefore, releases are not needed. The samples of canceled checks were reviewed and each check was cashed within two weeks of the paid date shown on the check. Each of the checks in the sample contained the correct payee and amount. The Company checks did not use the

terminology "final." The endorsements on each of the checks in the sample were consistent with the payee listed on the checks.

Table L 10 Claims

Closed Without Payment Claims	Sampled	N/A	Pass	Fail	% Pass
Individual Claims	10	0	10	0	100%
Small Group Claims	10	0	10	0	100%
Large Group Claims	10	0	10	0	100%
TOTAL	30	0	30	0	100%

Recommendations:
None

Standard L 11 *NAIC Market Conduct Examiners Handbook - Chapter XVII, § L, Standard 11*
Review Methodology: Sample
Standard: Statutory
Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.

Tenn. Code Ann. § 56-8-104(8)(A)(iv) and (x)

Comments:
None.

Results:
Pass

Observations:
The entire population of twenty-six (26) litigated claim files was selected for testing. The litigated files reviewed did not indicate problematic claim handling practices and did not indicate the Company compelled claimants to institute litigation to collect benefits due under policies.

Recommendations:
None

Standard L 12 *NAIC Market Conduct Examiners Handbook - Chapter XVII, § L, Standard 12.*
Review Methodology: Generic
Standard: Statutory
The company complies with the requirements of The Newborns' and Mothers' Health Protection Act of 1996.

Tenn. Comp. R. & Regs. 0780-1-68

Comments:
There is no Tennessee statute that mentions or has the same requirements as The Newborn's and Mother's Health Protective Act.

Results:
Pass

Observations:
The Company complies with the requirements of the New Born and Mothers' Health Protection Act of 1996. Benefits outlined in member certificates and handbooks were in accordance with the Newborns' and Mothers' Health Protection Act. Federal law is more restrictive than Tennessee statutes and the Company follows the Federal law. No deviation from the law was detected in claim testing.

Recommendations:
None

Standard L 13 *NAIC Market Conduct Examiners Handbook - Chapter XVII, § L, Standard 13.*
Review Methodology: Generic
Standard: Statutory
The company complies with the requirements of the Mental Health Parity Act of 1996.

Comments:
Mental Health Parity Act ("MHPA") requirements do not apply to: (1) small employer groups of two (2) to twenty-five (25) employees or (2) any group health plan where the required federal notice has been filed documenting that costs increased one percent (1%) or more due to the application of the MHPA requirements for at least six (6) consecutive months. The law does not affect the terms and conditions (such as cost sharing, limits on numbers of visits or days of coverage and requirements relating to medical necessity) relating to the amount, duration or scope of mental health benefits. MHPA protections apply to benefits for mental health services as defined under the terms of the Company contract or policy, but do not extend to benefits for substance abuse or chemical dependency. MHPA does not apply to any policies sold in the individual market.

Results:
Pass

Observations:
The Company Explanations of Coverage and Member Handbooks were reviewed for adherence to the above criteria and Company procedures and policies were reviewed to verify that the annual or lifetime dollar limits on mental health benefits are not lower than the dollar limits for medical and surgical benefits. No exceptions were noted.

Recommendations:
None

Standard L 14 *NAIC Market Conduct Examiners Handbook - Chapter XVII, § L, Standard 14.*
Review Methodology: Generic
The Company complies with statutes, rules, and regulations for group coverage replacements.
Tenn. Code Ann. § 56-7-2312

Comments:
None

Results:

Pass

Observations:
The Company complies with Tenn.. Code Ann. § 56-7-2312 with regard to group coverage replacements particularly in regards to pre-existing conditions. On a discontinued or replaced group policy, the Company automatically provides an extension of benefits to qualified individuals that are confined in a hospital on the date a group contract is discontinued.

Recommendations:
None

LIST OF RECOMMENDATIONS

Recommendation B-4
It is recommended the Company adopt and implement written procedures in accordance with Tenn. Code Ann. § 56-1-106(a), which requires a written response to the TDCI within thirty (30) calendar days.

Recommendation D-2
It is recommended the Company comply with HIPAA provisions that require commission levels for the sale of products to applicants with less favorable risk characteristics not be at levels below those paid for sales of products to applicants with more favorable risk characteristics.

Recommendation F-2 (a)
It is recommended the Company adopt and implement procedures to ensure producers are properly licensed and appointed prior to negotiation or solicitation of business.

Recommendation F-2 (b)
It is recommended the Company adopt and implement procedures to ensure producers evidence Errors and Omissions coverage prior to appointment.

Recommendation F-3
It is recommended the Company maintain accurate and complete records of terminated producers and provide written notice to terminated producers and the TDCI as required by Tenn. Code Ann. §§56-6-117.

Recommendation F-5
It is recommended the Company maintain accurate and complete records of terminated producers.

Recommendation H-2
It is recommended that the Company amend its procedures to comply with the statutes.

Recommendation J-8
It is recommended the Company adopt and implement written guidelines and procedures to establish that producers and Company personnel may make additions or changes to applications for administrative purposes only and properly define what additions or changes that would be considered administrative in nature so as to ensure compliance with the provisions of Tenn. Code Ann. § 56-26-118.

Recommendation J-11
It is recommended the Company not include in policy forms the termination provisions not permitted per Tenn. Code Ann. § 56-7-2810(b).

ACKNOWLEDGMENT

The customary insurance examination practices and procedures as promulgated by the NAIC have been followed in the performance of this Full Scope Market Conduct Examination of **BlueCross BlueShield of Tennessee, Inc.** as of September 30, 2004, consistent with the applicable statutes, rules and regulations of the State of Tennessee.

In addition to the undersigned, the following representatives of Huff, Thomas & Company and the TDIC participated in the examination of BlueCross BlueShield of Tennessee, Inc.:

Timothy R. Nutt, CIE	Examiner-In-Charge
Alvin Burrell, CFE	Participating Examiner
Brandon C. Thomas	Participating Examiner/Asst. IS Specialist
Hernan Macapanpan, CFE	Participating Examiner
Chauvin G. Alleman, CFE	Participating Examiner
James P. Benham, CIE	Participating Examiner
Michael Lamb, AIE, AIRC	Participating Examiner

Respectfully submitted,

Cecil W. Thomas, CIE, CFE
Supervising Examiner
Huff, Thomas & Company
For the State of Tennessee
Department of Commerce and Insurance

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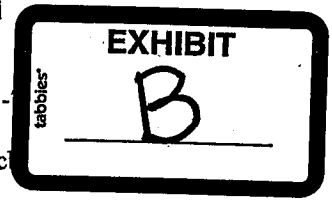

FEDERAL EXPRESS

January 15, 2008

Mr. Philip Blustein, CFE
Insurance Examinations Director
State of Tennessee
Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, Tennessee 37243

Dear Mr. Blustein:

We appreciate the opportunity that was provided to us for a 15-day formal review of the Market Conduct Examination Report on BlueCross BlueShield of Tennessee (BCBST) made as of September 30, 2004. We are extremely pleased with the overall positive findings of this exam. In accordance with your request in the letter dated December 20, 2007, enclosed are our comments with respect to the information contained in the report.

As indicated by the results of the Market Conduct Examination, we are committed to conducting business with ethics and integrity for the benefit and protection of the insurance buying public. We look forward to our continued relationship as a trusted partner of the Tennessee Department of Commerce and Insurance in providing the citizens of Tennessee with affordable and quality health care services.

Please let us know of any questions you may have or further actions required of us in connection with the issuance of the Market Conduct Examination Report for BCBST.

Yours very truly,

Bill Young
Senior Vice President of Risk Management
& General Counsel

Enclosure

cc (Enclosure):
Vicky Gregg, Joan Harp, John Giblin, David Locke, Clay Phillips – BCBST

BlueCross BlueShield of Tennessee (BCBST) Response to the Tennessee Department of Commerce and Insurance (TDCI) Market Conduct Examination Report – As of 9/30/04 January 15, 2008

General Review Response

Executive Summary – Page 6

Based upon the examiner's review of our response to the 9/14/07 draft report, the result of Standard C 4 was changed from a "fail" to a "pass". This change was also reflected in the current list of recommendations exhibited on page 75 of the 12/20/07 report. However, the change was not reflected in the Executive Summary section. In order for the Executive Summary to be in agreement with the detail of the 12/20/07 report, we believe the first sentence of the second paragraph should read "Of the one hundred four (104) standards tested, the Company passed one hundred two (102) and failed two (2)."

Recommendations Review Response

Standard B 4 – Page 17 & 18

The identified exceptions occurred early in the exam coverage period and prior to a change in the policies, procedures and responsibility areas handling TDCI inquires. Because the company now has an internal policy and procedures regarding timely response to Tennessee Department of Insurance inquiries, no additional corrective action is deemed warranted at this time. BCBST will continue to monitor and audit its procedures and responses to ensure compliance.

Standard D 2 – Page 23 & 24

Although BCBST did not pay commissions on its Guaranteed Issue (GI) HIPAA policies when this issue was raised during the exam, such practice does not constitute a failure to offer coverage to HIPAA eligible individuals. As set forth in 45 C.F.R. 148.120, HIPAA prohibits issuers from declining to offer coverage to HIPAA eligible individuals, and as set forth in its 1998 Program Memorandum, CMS (formerly Health Care Financing Administration) monitors practices such as non-payment of commissions on HIPAA policies to ensure that such practices do not constitute failure to offer coverage. Upon receipt of the 1998 memo, BCBST again evaluated its practices for compliance and determined that the non payment of commissions on these products did not constitute a failure to offer coverage and therefore, did not constitute a violation of law.

BCBST does not have a policy of discouraging brokers from selling HIPAA eligible individuals GI policies. To the contrary, we encourage our brokers to fully explain all options to clients seeking individual coverage. At the time this issue was raised, it should be noted that 25% of all GI HIPAA individual policies that were underwritten by BCBST were sold by brokers, with 12% being sold by general agents. The remaining 63% were sold by BCBST employees through direct telemarketing solicitations.

Nonetheless, effective 6/1/05, BCBST began paying commissions on the sale of new GI products to HIPAA eligible individuals. While we do not believe that our previous practice with regard to the sale of these products is contrary to or in any way a violation of 45 C.F.R. 148.120, as evidenced by the fact that such products were being sold by brokers and general agents, we have made this change in light of CMS's findings and actions against another insurer.

Standard F 2 (a) & (b) – Page 31 & 32

(a) The Broker Administration Department has procedures in place to verify and obtain evidence that producers are properly licensed and has Errors and Omissions coverage prior to appointment with the TDCI to negotiate or solicit business on behalf of BCBST. The two exceptions noted in the exam sample were the result of file documentation issues that have been evaluated with proper actions taken to prevent these occurrences in the future.

(b) The Broker Administration Department has procedures in place to verify and obtain evidence that producers are properly licensed and has Errors and Omissions coverage prior to appointment with the TDCI to negotiate or solicit business on behalf of BCBST. The two exceptions noted in the exam sample were the result of file documentation issues that have been evaluated with proper actions taken to prevent these occurrences in the future.

Standard F 3 – Page 32

During the coverage period of the examination, BCBST terminated 228 of its approximately 4500 active producers. In order to enhance the producer record retention process, BCBST implemented procedures in December 2004 that requires all documents related to producer terminations be scanned and placed into a Broker Administration file on the corporate server. This folder is accessible only to those with the appropriate security clearance. In addition, Broker Administration personnel have been instructed to send proper notification to producers and the TDCI at the time of termination.

Standard F 5 – Page 33

During the coverage period of the examination, BCBST terminated 228 of its approximately 4500 active producers. In order to enhance the producer record retention process, BCBST implemented procedures in December 2004 that requires all documents related to producer terminations be scanned and placed into a Broker Administration file on the corporate server. This folder is accessible only to those with the appropriate security clearance.

Standard H 2 – Page 39

(a) Based upon the comments of this standard, an absence of a direct statutory requirement for policy issuance and the recommendation included in the 12/20/07 report, we believe that the words "policy issuance and" in the last sentence of the observations section should be removed. The statement should read "Company procedures for insured requested cancellations are not in compliance with this standard.". Also, we believe that the recommendations section should be clarified by inserting the word "cancellation" in front of the word "procedures" and read as "It is recommended that the Company amend its cancellation procedures to comply with the statutes.".

(b) BCBST did not become aware of this issue until performing a review of the draft Market Conduct Examination Report during the 30 day comment period. Although we would have preferred to address this issue as an inquiry during the fieldwork phase of the examination, our response is based upon the information provided in the report. BCBST complies with the law as set forth in TCA 56-26-109(8) but does not have a formal written procedure. We will prepare a formal written procedure to reflect our administration of this requirement. Although we intended to complete this step by 12/31/07, we are still in process of finalizing the written procedures.

Standard J 8 – Page 50 & 51

According to state law, alteration of an application for insurance coverage can be made by a person other than the applicant only with the applicant's written consent. However, alterations may be made by the insurer, for administrative purposes only, in such a manner as to indicate clearly that such alterations are not to be ascribed to the applicant. Whenever possible, BCBST marketing personnel request applicants to correct any incomplete or incorrect information on the applications. However, in instances where the applicants are unavailable to make the corrections resulting in significant delays in setting up coverage, marketing personnel make the corrections on the application with their initial and date clearly noted beside change. In addition, if information is received from a group or broker that requires a correction to the application, retention of that direction will be maintained in the group file at the regional office. These instructions have been communicated to all sales and account management personnel to assure compliance.

Standard J 11 – Page 52 & 53

The language of the termination provision was intended to reinforce the statutory prohibition regarding material misrepresentations and fraud found in 56-7-2810 (b) (2). Upon review, it was determined that the language should be removed and we made an informational filing with the TDCI to remove item #3 under "Termination of Policy".